Dental Manual

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Dental Program Overview

The Department of Health Care Policy and Financing (the Department) periodically modifies the dental benefits and services. Therefore the information in this manual is subject to change, and the manual is updated as new policies are implemented.

After reviewing this document, please refer to the latest dental bulletins in the Provider Services Bulletins section of the Department's website (colorado.gov/hcpf), for the most current information about updates and changes to the program. Dental bulletins list specific American Dental Association (ADA) Current Dental Terminology (CDT) dental procedure codes that are Colorado Medical Assistance Program services for all clients age 20 and under, clients age 21 and older, and non-citizens.

- April 2014 Provider Bulletin (B1100297)- Adult Dental Program Policy and Billing Information
- January 2010 Provider Bulletin (B1000279)- Orthodontic Program Changes

Comprehensive orthodontic therapy and associated orthodontic services are listed in this bulletin, which is for dental providers enrolled as a dentist *with* an orthodontic specialty designation only.

Note: A new billing manual will be effective July 1, 2014, that will describe additional covered benefits, age limits, frequencies and prior authorization requirements.

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program client; and
- Submit claims for payment to the Colorado Medical Assistance Program.

Enrollment Options for Oral and Maxillofacial Surgeons

Oral and maxillofacial surgeons (graduates from an ADA accredited oral and maxillofacial surgery program) must choose between enrolling as a dentist and bill according to all dental billing requirements using Current Dental Terminology (CDT) codes, or enrolling as a physician and bill according to all medical billing requirements using Current Procedural Terminology (CPT) codes.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

The 2006 ADA claim form is the only form accepted by the Colorado Medical Assistance Program when submitting all dental claims and prior authorization requests (PARs) for dental services provided to Colorado Medical Assistance clients. All other versions will be returned for resubmission.

The 2006 ADA form is available from the American Dental Association at:

211 East Chicago Avenue
Chicago, IL 60611-2678

www.adacatalog.org or 1-800-947-4746

Forms may be purchased directly from the ADA or vendors. The year of the form is shown on the lower left corner. If you are using your computer system to generate paper claim forms, contact your software vendor to determine if the 2006 ADA claim form is installed as a part of your software.

All ADA **paper** claims received by the Department's fiscal agent without a signed Dental Provider Certification form attached will deny for "no signature on file" regardless of the dates of service. The certification form requires the ***original signature*** of the provider.

Note: The certification form does not need to be submitted with the Dental Prior Authorization Request.

The certification form is included at the end of this manual and in the Provider Services Forms section of the Department's website.

Providers are required to submit claims electronically unless the Department has given the provider specific authorization to submit hard copy claims Requests for paper claim submission may be sent to Xerox State Healthcare, P.O. Box 90, Denver, CO 80201. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 or fewer claims per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims
- Claims from orthodontic providers only for orthodontic treatment of an approved handicapping malocclusion

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Third Party Liability

Medicaid is the payer of last resort. If a client has an additional commercial insurance plan, that plan must be billed first and the amount reimbursed by the third party must be reflected on the Medicaid ADA claim form. Medicaid will pay the difference **only** if the commercial insurance reimburses less than Medicaid would reimburse for the same procedure. If the commercial insurance pays more, the provider will receive no additional reimbursement. The client cannot be billed for any differences.

Client Eligibility

Always verify eligibility **before** rendering services.

Why should eligibility be verified? The provider who checks a client's eligibility on the day of service and finds the client eligible receives an eligibility guarantee number. If eligibility has changed when the claim is submitted, the guarantee number exempts those claims from eligibility edits for that date of service. This simple process can save the provider a lot of paper work in the future.

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D *(wpc-edi.com/)*
- Companion Guides for the 837P, 837I, or 837D in the Provider Services Specifications section of the Department's website
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system. Please refer to the Colorado 1500 General Billing Information Manual for additional electronic billing information.

Prior Authorization Requests (PARs) for Dental Services

The ColoradoPAR Program processes **electronic** Dental and Orthodontic PARs through CareWebQI (CWQI). CWQI collects user demographic information and allows the user to upload and transfer PARs electronically. All clinical documentation, **including digital X-rays**, will be accepted in the following forms:

doc; docx; xls; xlsx; ppt; pdf; jpg; gif; bmp; tiff; tif; jpeg

If the clinical documentation cannot be submitted electronically, submit relevant clinical information by dedicated fax or mail when applicable to ColoradoPAR at:

Dental Fax Line: 1-866-667-4823

Mail: 55 N. Robinson Avenue, Suite 600
Oklahoma City, OK 73102

PAR Requirements

None of the covered dental services for adults age 21 and older, available as of April 1, 2014 to June 30, 2014, will require a PAR. Although clients and non-citizen ages 20 and under from April 1, 2014 to June 30, 2014 have different PAR requirements for dental procedures.

Review the most current dental Provider Bulletins, which list the PAR requirements for each dental procedure. Current bulletins are listed on page 1 of this manual.

Emergency Services

Emergency services do not require a PAR before services can be rendered. Adult clients who currently receive Medicaid and need emergency dental services may receive such services, regardless of cost.

Emergency services are the need for immediate intervention by a physician, osteopath or dentist to stabilize an oral cavity condition. Emergency dental treatment are services that must be rendered within twelve (12) hours.

Example of code with a PAR requirement

The dental provider bulletins list billable codes. If a code has a PAR after, it means a PARis required for the procedure. See the example below.

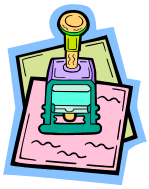
Clients through age 20
Crowns – single restorations only
D2751 PAR crown – porcelain fused to predominantly base metal

PAR Guidelines

Any provider submitting a PAR must be enrolled in the Colorado Medical Assistance Program for each date of service. Providers must also verify eligibility at the time service is rendered and include the necessary information with the PAR.

Provide the following information with all Dental PARs

- Describe the dental condition supporting the need for the service under "Remarks" which is field #35 on the ADA 2006 form.
- Please do not send diagnostic models unless requested to do so by the ColoradoPAR dental consultant.



Dental PARs that have administrative issues such as missing information, missing malocclusion forms or requiring further information will be pended. The provider will receive a letter indicating that the PAR is pended and describing which missing documentation or forms must be submitted. Providers must submit the required documents within 45 days, or the PAR will be denied. The provider and client will no longer receive denial letters when there is missing documentation. Only the provider will receive a pended PAR letter discussing what is missing. A pended PAR is not a denial and therefore **cannot** be appealed. When the dental provider receives the pended PAR notification, they must submit the entire PAR again along with the requested documents and a copy of the PAR letter.

The ColoradoPAR Program dental consultants evaluate the proposed services submitted by the provider and approve or deny the procedure.

Approval of a PAR does not guarantee reimbursement from the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements before reimbursement can be made (e.g., ages 20 and under for EPSDT services, timely filing, third party resources payments pursued, required attachments included etc.)

PAR status may be verified through CareWebQI (CWQI).

Claims for prior authorized services must be submitted within 120 days of the date of service. Services not rendered within 120 days require a new PAR. Services rendered prior to the authorized date will be denied reimbursement. Claims approved for comprehensive orthodontic treatment are an exception to this policy. These claims should be submitted within six months of the date of service.

PAR Requirements for clients age 16-20

The services listed below require a PAR for clients age 16 through age 20 from April 1, 2014 to June 30, 2014. None of the covered dental services for adults age 21 and older, that are available as of April 1, 2014, will require prior authorization.

- Single crowns; core build-ups; post and cores
- Full and Partial Dentures
- Scaling and Root Planing
- Root Canals, however, pupal debridement in instances of acute pain, does not require a PAR.
- Non-emergency Surgical Extractions
- Minor surgical procedures
- General Anesthesia and Deep Sedation, except in cases of acute pain.

Prior authorizations and/or benefits may be denied for reasons of poor dental prognosis; lack of dental necessity or appropriateness, or not meeting the generally accepted standard of dental care. Approval of a PAR does not guarantee reimbursement.

Paper Prior Authorization Form

The Dental Provider Certification form does not need to be submitted with paper **PARs**. Submit the certification form with paper **claim** forms only.

The 2006 ADA Dental claim form is used for both the PAR and for reimbursement of services.

When dental services require prior authorization, complete the claim form in the same manner as for billed services. Enter the name and telephone number of the dentist requesting the PAR and the Colorado Medical Assistance Program provider number. Include all client information, codes for requested services, descriptions, charges, etc. Leave the date of service fields blank. **Do not sign or date the PAR.**

Instructions for completing the 2006 ADA claim form for PARs are included at the end of this manual.

No dental provider, including orthodontists, should send diagnostic casts, study models, or x-rays with a PAR unless requested to do so by the reviewer's dental consultant.

Billing Guidelines

Frequency limits as described are every 12 months, or every year, which refers to the State's Fiscal Year of July 1 to June 30.

Dental offices and medical offices are encouraged to communicate with one another to avoid duplication of services and/or non-payment of services.

Note: If there is more than one way of treating a condition; then the treatment that is sufficient and less costly will be reimbursed. The provider may not charge for the more costly procedure. For example, if the provider uses a composite material where an amalgam could have been used, the provider will be reimbursed *as if* they had used amalgam. The provider may use composite if they choose; however, cannot bill the client for the difference in price between an amalgam restoration and a composite restoration.

If the provider completes a pulpal debridement procedure, and subsequently completes a root canal on the same tooth; then payment for the pulpal debridement will be subtracted from the final root canal payment.

If a procedure is not listed, the procedure is not covered*,* unless special consideration and approval has been obtained, to reflect extenuating circumstances.

Benefits and/or PARs may be denied for reasons of poor dental prognosis; lack of dental necessity, appropriateness, or not meeting the generally accepted standard of dental care. Approval of a PAR does not guarantee Colorado Medical Assistance Program reimbursement.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Dental Services for Clients through Age 20

Federal Medicaid regulations require states to provide coverage for comprehensive dental services for Medicaid enrolled children from birth to the 21st birthday under a set of requirements referred to as "Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The federal EPSDT requirement is for coverage of services determined to be medically necessary to treat conditions discovered at screening and diagnosis. At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health, including examinations, cleanings, and fluoride treatments**. The ColoradoPAR Program makes the final determination of medical necessity** and it is determined on a case-by-case basis. Provider recommendations will be taken into consideration, but are not the sole determining factor in coverage. The ColoradoPAR Program determines which treatment it will cover among equally effective, available alternative treatments.

All Colorado Medicaid eligible children through age 20 and under are entitled to coverage for such EPSDT services. Colorado Medicaid recommends regular periodic examinations by a dentist with eruption of the first tooth or at age one (1), and continuing every six (6) months or as recommended by the dentist.

EPSDT outreach coordinators are based in local community agencies. These coordinators provide outreach and case management services to clients through age 20 enrolled in the Colorado Medical Assistance Program. Outreach coordinators contact the family or client to inform them of medical and dental benefits.

The outreach coordinator assists the family in finding a local dentist and in making and following up on appointments. Outreach coordinators may re-contact families or individuals for needed services or appointment reminders. The EPSDT Toolkit may be accessed through the Colorado Medical Assistance Program section of the Department's website.

Clinical Oral Evaluations

A comprehensive oral evaluation (exam) for a new or established client is allowed once every **three (3) fiscal years** per billing provider. This applies to new clients, established clients who have had a significant change in health conditions or other documented unusual circumstances, or established patients who have been absent from active treatment for three or more years. This includes a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures.

A comprehensive periodontal oral evaluation is allowed once every three fiscal years, which counts as one of two (2) exams per fiscal year, and is limited to ages 15 through 20. The benefit is limited to any combination of two comprehensive, periodic or periodontal evaluations within a fiscal year, and may only be performed by a dental professional.

A periodic oral evaluation is an evaluation performed on a client of record to determine any changes in the client's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. A periodic oral evaluation is allowed twice per fiscal year per client by the same provider or one time when it is performed in the same year as a previously administered comprehensive oral evaluation. Any combination of oral exams (periodic, comprehensive or periodontal) are limited to two per fiscal year. The oral evaluation (for a client under three years of age) or screening is not payable on the same date of service as a periodic oral evaluation.

Limited oral evaluation is covered when used as defined in the current ADA Practical Guide to Dental Procedure Codes (CDT manual), which describes a limited, problem focused oral evaluation related to a specific oral health complaint. This may require interpretation of information acquired through additional diagnostic procedures, which should be reported separately. Definitive procedures may be required on the same date as the evaluation. Clients receiving this type of evaluation typically present with specific problems and /or dental emergencies, trauma or acute infections. Limited oral evaluations will be tracked separately and will not count as part of the two oral exams allowed per fiscal year.

Note: Dental hygienists may only provide limited oral evaluations for an established client of record. This code should not be used to address situations that arise during multi-visit treatments covered by a single fee, such as endodontic therapy, routine surgical follow up visits, or orthodontic adjustments. This code should not be used to bill for post-operative visits in surgical cases, for non-clinical encounters with clients such as telephone conversation, or for ordering prescription medication on behalf of a client.

Pediatric Clients

An oral evaluation for a patient less than three years of age and counseling with the primary caregiver is available for a new or established client twice per fiscal year, unless the client is high risk, then three per fiscal year up to the day before the third birthday. This service includes recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver. An oral evaluation is not reimbursable on the same day of service as any other clinical oral evaluation or screening.

Screening, including state or federally mandated screenings, may be done to determine an individual's need to be seen by a dentist for diagnosis. Screenings are not reimbursable on the same day of service as any other clinical oral evaluation. Screening one time per fiscal year after age five (5) through age 20. Does not count towards other oral evaluation frequency limits.

Radiographs

A minimum of ten (10) films is required for an intraoral - complete series (full mouth series, complete series). A panoramic film with or without bitewing radiographs is considered equivalent to an intraoral - complete series and cannot be billed on the same date of service as a full mouth series without prior authorization. The minimum age for a panorex is six years and is allowed one time per five fiscal years.

- An intraoral - complete series is allowed once every five fiscal years by the same billing dental provider.
- Intra-oral first periapical x-ray, six per five fiscal years. Providers may not bill the same day as full mouth series.
- Each additional periapical x-ray. Providers may not bill the same day as a full mouth series. Working and final treatment films for endodontics are not covered.
- Bite-wings, whether a single image, or two, three or four images, are allowed once per fiscal year. One set is equal to 2-4 films.
- Vertical bitewings; seven (7) to eight (8) images, are allowed once every five fiscal years and count as a full mouth series.
- Occlusal films are allowed for children through age 20 one time per two fiscal years.

The exception to this limitation is when the client is new to the office or clinic and they were unsuccessful in obtaining radiographs from the previous dental provider. Supporting documentation outlining the provider's attempts to receive previous radiographs must be included in the client's records.

Limited x-rays may be billed by two (2) different providers on the same date of service for the same client when one provider is a general dentist and the other is a dentist who has received post graduate training in one of the recognized dental specialties and is not under the same billing provider.

Any number or combination of intraoral radiographic films, with or without a panoramic film, on the same date of service is not allowed to exceed the maximum benefit for an intraoral – complete series.

Intra-operative radiographs cannot be billed separately as part of any endodontic or root canal procedure.

Covered Preventive Services
Dental Cleanings (Prophylaxis)

Topical Fluoride and Fluoride Varnish Treatments

Topical fluorides are a covered benefit for children through age 20, topical fluoride treatments are allowed twice per fiscal year. For medical providers, the varnish must be done at a well-child visit and in conjunction with an oral evaluation for a client under age three (up until the day before the third birthday); or in conjunction with a screening for clients ages three to five (up until the day before the fifth birthday.) After age five, only qualified dental providers may perform this service. After age five, the limit is two per fiscal year, with no adjustment for risk. After age six, any combination of fluoride varnish or topical fluoride is limited to two per fiscal year.

Fluoride varnish is considered the standard of care and is the only acceptable topical treatment (up to the day before their sixth birthday), however, either topical fluoride or fluoride varnish may be used for clients after the sixth birthday. Fluoride rinse is not an acceptable treatment.

Below is a list of topical fluoride and fluoride varnish benefits for clients with the following:

- Fluoride varnish, two (2) per fiscal year is a benefit for clients with:
  - dry mouth; and/or
  - history of head or neck radiation; or
  - high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the fiscal year they no longer have active decay, they are no longer considered high risk.
- Topical fluoride, two (2) per fiscal year is a benefit for clients with:
  - dry mouth; and/or
  - history of head or neck radiation; or
  - high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the fiscal year they no longer have active decay, they are no longer considered high risk.
- For adults age 21 and over, fluoride varnish is allowed twice per fiscal year for clients with:
  - dry mouth; and/or
  - history of head or neck radiation; or
  - high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the fiscal year they no longer have active decay, they are no longer considered high risk.
- For adults age 21 and over, topical fluoride is allowed twice per fiscal year for clients with:
  - dry mouth; and/or
  - history of head or neck radiation; or
  - high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the fiscal year they no longer have active decay, they are no longer considered high risk.

A PAR is not necessary, but a description of the high-risk condition for any age client must be documented in the client's dental record, in the event of an audit.

Medical providers administering preventive fluoride treatments and screenings

Trained medical personnel (see qualifications below) may administer fluoride varnish at a well-child visit to Medicaid clients ages birth through four (until the day before their fifth birthday) who have moderate to high caries risk. A fluoride varnish may be administered only after a risk assessment is completed. Risk assessment forms may be found either at Cavity Free at Three or in the Provider Services Forms section of the Department's website. Documentation of risk using these forms must be part of the client's medical record. A fluoride varnish must be administered together with an oral evaluation with counseling by a primary caregiver, or a screening.

Medical personnel who may bill directly for the above services include MDs, DOs, nurse practitioners and physician assistants. Trained medical personnel employed through qualified physician offices or clinics may provide these services during a well-child visit and bill using the physician's or nurse practitioner's Medicaid provider number. In order to provide this benefit and receive reimbursement, the medical provider must have participated in on-site training from the "Cavity Free at Three" team or have completed Module 2 (child oral health) and Module 6 (fluoride varnish) at the Smiles for Life curriculum.

Medical personnel who complete the training must save the documentation for this training in the event of an audit.

Billing Procedures for Medical Personnel

For children ages birth-through age two (until the day before their 3rd birthday):

Private practices: D1206 (topical fluoride varnish) and D0145 (oral evaluation for a patient under three (3) years of age and counseling with primary caregiver) must be billed on a Colorado 1500 paper claim form or electronically as an 837P transaction.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): D1206 and D0145 must be itemized on the claim with a well-child visit, but reimbursement will be at the current encounter rate.

The diagnosis V72.2 (dental examination) should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I transaction.

For children ages three and four (from their third birthday until the day before their 5th birthday):

Private practices: D1206 and D0999 (dental screening) must be billed on a Colorado 1500 paper claim form or electronically as an 837P transaction in conjunction with a well-child visit.

FQHCs and RHCs: D1206 and D0999 must be itemized on the claim with a well-child visit but reimbursement will be at the current encounter rate. The diagnosis V72.2 (dental examination) should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I transaction.

Dental providers, including Direct Access/Independent dental hygienists, are also able to provide these services. While encouraged, no additional training is required for qualified dental personnel.

The maximum allowable benefit per eligible and high risk child will be three (3) times per fiscal year. Dental offices and medical offices are encouraged to communicate with one another to avoid duplication of services and/or nonpayment of services.

Charges for supplies used in self or home application of fluoride are not a benefit.

Dental Prophylaxis

Teeth cleanings are allowed every six months, and may be reimbursed twice per fiscal year per client. Prophylaxis is not a benefit when billed on the same date of service as any periodontal procedure code.

To be covered by the Colorado Medical Assistance Program, dental prophylaxis must be performed and submitted in accordance with the ADA CDT description for D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis) These procedure codes are described as “removal of plaque, calculus, and stains from the tooth structure.” Claims for “toothbrush prophylaxis” should not be coded as D1110 or D1120, nor submitted for payment. The Colorado Medical Assistance Program does not reimburse for toothbrush prophylaxis.

Clients are eligible for up to four cleanings per year if they are at a high risk for periodontal disease. They are considered to be at high risk if they have a history of:

- periodontal scaling,
- root planing,
- periodontal surgery,
- diabetic, or
- pregnant

Patients who are determined to fit into the high risk category, are eligible for any combination of periodontal maintenance visits and cleanings, up to four a year.

Sealants

Sealants may be applied twice per lifetime per tooth to the occlusal surface of any permanent first or second molar at risk for occlusal pit and fissure decay. A separate benefit will not be paid for sealant placed in the facial (buccal) pit and/or fissure of a permanent molar tooth. Sealants may be applied to all unrestored permanent molars without a cavitated lesion in clients ages five through age 15.

Space Maintainers

Providers may bill for space maintainers once per lifetime per quadrant only to hold arch space after the premature loss of a first or second primary molar or a permanent first molar, or congenitally missing permanent tooth. A provisional prosthesis (interim partial denture) designed for use over a limited period of time is also a covered benefit but must be prior authorized. Fees for space maintainers include maintenance and repair. The maximum client age for a space maintainer is 14 years of age. Fees for space maintainers include maintenance and repair. Recementation of space maintainers is allowed once (1) per fiscal year; not paid within six months of original placement by the same dentist.

Restorative

Routine amalgam fillings on posterior teeth and composite fillings on anterior teeth are covered services. Tooth preparation, anesthesia, all adhesives, liners and bases, polishing and occlusal adjustments are included as part of the restoration. If pins are used, they should be billed separately.

Refer to the most current American Dental Association publication, *Current Dental Terminology* (CDT) for definitions of restorative procedures. Unbundling of dental restorations (fillings) is not allowed. The total restorative fee for a primary tooth cannot exceed the current maximum benefit for a prefabricated stainless steel crown. Multiple one surface restorations placed in the same tooth, on the same surface, during the same visit is a single restoration. Reimbursement for amalgam and resin restorations includes all necessary bases and liners.

The occlusal surface is exempt from the 36-month frequency limitation when a multi-surface restoration is required or following endodontic therapy.

Claim payment to a dental provider for one or more restorations for the same tooth is limited to a total of four (4) tooth surfaces.

Restorations for permanent and primary teeth are paid at the same rate.

An amalgam or composite restoration and a crown on the same tooth same date of service is not allowed. A core buildup, including any pins is allowed along with a crown on the same tooth on the same date of service. Amalgams and composite restorations are reimbursed at the amalgam rate.

Restorative Procedures

Permanent crowns are only approved for clients age 16 through age 20, from April 1, 2014 to June 30, 2014.

Crowns are covered services when:

- The tooth in question requires a multi-surface restoration and when it cannot be restored with other restorative materials.
- The client's record reflects evidence of good and consistent oral hygiene.
- Only when the cause of the problem is either decay or fracture.
- The tooth is in occlusion.
- The tooth is not a second or a third molar; the second molar is covered if it meets all of the above criteria and it is necessary to support a partial denture or to maintain at least eight (8) posterior teeth (artificial or natural) in occlusion.

- If a crown is requested for cracked tooth syndrome; then the tooth must be symptomatic and appropriate testing and documentation must be provided.

The following will be covered benefits if:

- The tooth is necessary to support a partial denture and the above criteria are met.
- The tooth is necessary to maintain at least eight (8) posterior teeth (artificial or natural) in occlusion and the above criteria are met.

Crown materials will be limited to porcelain and noble metal, or full porcelain, on anterior teeth and premolars. Full noble metal crowns will be the material of choice for premolars and molars. Full porcelain crowns may also be used when esthetics is an issue.

Indirect post and cores are a benefit for all permanent teeth. Prior authorization is required. Porcelain crowns placed primarily for aesthetic reasons are not a covered benefit.

Prefabricated stainless steel crowns are a benefit for both primary and permanent teeth. Prefabricated resin crowns, prefabricated stainless steel crowns with a resin window, and prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth. **When treating children under the age of 21, a maximum of five crowns may be prepared and inserted on the same day of service in a non-hospital setting unless in-office sedation is provided.**

Crowns are covered if there is significant loss of clinical crown, and/or the tooth has completed endodontic treatment and no other restoration will restore function. Crowns will not be covered in cases of advanced periodontal disease, poor crown to root ratio, or generalized poor prognosis.

Payment for preparation of the gingival tissue cannot be billed separately and is included in the global payment for a crown.

Pin retention – per tooth, in addition to restorations, is limited to four per tooth. Pin retention is not covered when a core buildup is also billed for the same tooth on the same date of service.

Fixed partial dentures for clients through age 20 are a benefit for permanent teeth, from April 1, 2014 to June 30, 2014. Prior authorization is required. This includes porcelain fused to predominately base metal, connector bars, stress breakers, precision attachments, post and cores and copings.

Refer to the current CDT for classification of materials.

Endodontic Therapy

Endodontic therapy is a covered benefit for clients through age 20 from April 1, 2014 to June 30, 2014.

Therapeutic pulpotomy with the aim of maintaining the tooth vitality is a benefit for primary teeth and permanent teeth. It is not intended to be the first stage of conventional root canal therapy.

Pulpal therapy, including pulpectomy, cleaning and filling of canals with resorbable material is a benefit for all primary teeth with that are succedaneous teeth.

Endodontic therapy is a covered benefit for permanent teeth, excluding third molars and all primary teeth without succedaneous teeth.

Pulpal debridement is covered in emergency situations only and exempt from requiring a PAR; but may be subject to post-treatment and pre-payment review. Pulpal debridement is not payable when the root canal is completed on the same day by the same dentist/dental office. Please refer to the **Emergency Services** section above for more information.

Direct and indirect pulp caps are a benefit when clearly documented in the dental records. All adhesives (including amalgam bonding agents), liners and bases are included as part of a restoration; they will not be reimbursed if billed separately.

Separate reimbursement for open and drain is only allowed prior to date of service for an extraction or root canal therapy.

Root canal therapy that has only been initiated or taken to some degree of completion, but not carried to completion with a final filling, may be billed as an incomplete endodontic therapy.

Third molars are excluded from endodontic therapy.

Palliative treatment is defined in the CDT as "action that relieves pain but is not curative." Palliative treatment on a tooth will not be reimbursed together with definitive treatment on the same tooth same date of service. Providers will not be reimbursed for palliative treatment when the only service delivered is writing a prescription. Similarly, an examination is not considered to be palliative treatment.

Root canal therapy and palliative treatment should not be billed by the same provider for the same client, the same tooth, and the same date of service.

Root Canals are covered services when:

- In instances of severe pain or trauma without a PAR. Such services may be subject to post-treatment, pre-payment review.
- The client's record reflects evidence of good and consistent oral hygiene.
- Only when the cause of the problem is either decay or fracture.
- The tooth is in occlusion.
- If the tooth is necessary to support a partial denture and the above criteria are met.
- If the tooth is necessary to maintain at least eight posterior teeth (artificial or natural) in occlusion and the above criteria are met.
- If a root canal is requested for cracked tooth syndrome; then the tooth must be symptomatic and appropriate testing and documentation must be provided.

Root canal retreatments will be covered as long as the client did not receive that original treatment while part of the Colorado Medical Assistance Program. If the Colorado Medical Assistance Program paid for the initial treatment, then the retreatment will not be covered.

Working films, including the final treatment film, for endodontic procedures are considered part of the procedure and will not be paid separately.

Clients of any age who are in acute pain should receive the necessary care. In these instances, there may not be time for prior authorization. In all instances in which the client is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency treatment. Note: Such emergency procedures may be subject to post-treatment and pre-payment review.

Periodontics

Periodontal services will only be a covered benefit for clients through age 20 from April 1, 2014 to June 30, 2014. Most periodontal procedures require prior authorization.

Diagnosis and classification of the periodontology case type must be in accordance with documentation as currently established by the America Academy of Periodontology.

Clear evidence of bone loss must be present on the current radiographs to support the diagnosis of periodontitis.

There must be current six point periodontal charting with mobility noted inclusive of periodontal prognosis.

Full mouth debridement will not be a covered service.

Scaling and root planing for four or more teeth per quadrant is a covered benefit. Local anesthetic or locally applied anesthetic may not be billed separately.

A maximum of two quadrants on one date of service is allowed, except in a hospital setting. Quadrants are not limited to physical area, but are further defined by the ADA code descriptor.

Studies indicate that clients at high risk for periodontal disease benefit from more than two periodontal maintenance visits per fiscal year. Clients with a history of periodontal treatment, including scaling, root planning and osseous surgery, will be eligible for four periodontal maintenance visits per fiscal year, since research indicates that more frequent maintenance will result in less likelihood of progressive disease.

Clients who are determined to fit into the high risk category for periodontal disease, are eligible for any combination of cleanings and periodontal maintenance visits, up to four per fiscal year.

Diabetics, who are at increased risk for periodontal disease, will be eligible for four cleanings or four periodontal maintenance visits per fiscal year.

Pregnant women are at increased risk for periodontal disease and therefore will be eligible for four cleanings or four periodontal maintenance visits during the year of their pregnancy.

A description of the high risk condition for any age client must be documented in client's dental record, in the event of an audit.

Gingivectomy or gingivoplasty is covered for severe fibrous gingival hyperplasia where enlargement of gum tissues occurs due to a concurrent medical condition.

Removable Prosthetics

Some prosthodontic services are covered only for clients through age 20 from April 1, 2014 to June 30, 2014: complete dentures, immediate dentures, partial dentures and relines and tissue conditioning and must be prior authorized. Removable prosthetics are not covered if more than eight posterior teeth (natural or artificial) are in occlusion. Coverage is provided, however, for anterior teeth, irrespective of the number of teeth in occlusion.

Interim complete dentures, overdentures or partials are a benefit for clients through age 20 from April1, 2014 to June 30, 2014, and must be prior authorized.

None of the covered dental services for adults age 21 and older, that are available as of April 1, 2014, will require prior authorization.

Clients with acquired, congenital or developmental defects of the head and neck are eligible for maxillofacial prostheses that serve to rehabilitate both esthetics and function. Clients exposed to chemotherapy, radiation or cytotoxic drugs, are also eligible for the necessary prostheses to restore both form and function.

Replacement of a removable prosthesis is allowed one time, if the replacement is necessary because the removable prosthesis was misplaced, stolen, or damaged due to circumstances beyond the client's control. When applicable, the client's degree of physical and mental impairment must be considered in determining whether the circumstances were beyond a client's control.

Replacement of partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the recipient's dental needs.

Service for a removable prostheses must include instruction in the use and care of the prosthesis and any adjustment necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. The dentist must document the instruction and the necessary adjustments, if any, in the client's dental record. Denture adjustments are a covered service only when performed by a dentist who did not provide the denture. Other services include the repair of a broken denture base, repair or replacement of broken clasps, replacement of teeth, and denture relines.

Oral Surgery

Oral Surgery services are available for clients through age 20, from April 1, 2014 to June 30, 2014.

None of the covered dental services for adults age 21 and older, that are available as of April 1, 2014, will require prior authorization.

In all instances in which a client of any age is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency treatment. Such emergency procedures may be subject to post-treatment and pre-payment review. Palliative treatment is an emergency service in order relieve client pain; however this is not a mechanism for addressing chronic pain. Please refer to the Emergency Services section above for more information.

Oral Surgery Covered Services

The Colorado Medical Assistance Program covers:

- Extractions of teeth that are involved with acute infection, acute pain, cyst, tumor or other neoplasm, radiographically demonstrable pathology that may fail to elicit symptoms and the extractions that are required to complete a Medicaid approved orthodontic treatment plan.
- Oral surgery procedures that include routine pre-operative and post-operative care, sutures, suture and/or wire removal and local anesthetics.
- General anesthesia and deep sedation **only** covered when there is sufficient evidence to support medical necessity.
    - All oral surgery procedures include local anesthesia and visits for routine postoperative care such as suture removal.
- Surgical access to an unerupted tooth and/or placement of a device to facilitate eruption of an impacted tooth.
    - Upon approval by the Colorado Medical Assistance Program for orthodontics.
    - A PAR is required.
- Incision and drainage of abscesses.
- Removal of maxillary or mandibular lateral exostosis, torus palatinus or mandibularis and surgical reduction of osseous tuberosities, tumors, cysts, neoplasms and reactive inflammatory lesions are a covered benefit.
- Alveoloplasty for surgical preparation of ridge for dentures and vestibuloplasties.
- Frenulectomy and frenuloplasty.
- Tooth reimplantation is covered in the event of tooth evulsion.
- Orthognathic surgery may be covered in conjunction with a prior authorized orthodontic treatment plan, trauma, or congenital defects.
- Treatment of simple and compound fractures, repair of traumatic wounds, and miscellaneous repair procedures

Clinicians should consult the provider bulletin to identify additional covered surgical procedures.

Oral Surgery Non-Covered Services

The following benefits are not covered:

- Extraction of primary teeth which are close to exfoliation;
- The routine removal of asymptomatic third molars
    - Only in instances of acute pain and overt symptomatology, will the removal of third molars be a covered service.

Whenever possible, necessary third molar extractions should be submitted for prior authorization. If unable to do so, then third molar extractions may be subject to post treatment and pre-payment review. Third molars exhibiting non-resorbable carious lesions, pulpal inflammation, recurrent infections, cyst and tumors are candidates for extraction

- General anesthesia and/or deep sedation is not covered when it is for the preference of the client or the provider, and there are no other medical considerations.
- Surgical access for placement of inter-dental wire ligatures or brass wire eruption spacers are not covered benefits
- Biopsies will not be a covered benefit as a routine procedure, but only in instances where there is a suspicious lesion.

Hospital-Based Services

Hospital-Based dental services are for clients through age 20 from April 1, 2014 to June 30, 2014.

Dental treatment is covered in a hospital or outpatient facility, under deep sedation or general anesthesia, only when such services are determined to be medically necessary. Benefits will not be paid for services paid in the operating room or outpatient facility when scheduled for the convenience of the provider or the client in the absence of medical necessity. All operating room cases must be prior-authorized, even if the complete treatment plan is not available.

Consistent with the Guidelines of the American Academy of Pediatric Dentistry, the following must be considered when contemplating treatment of a child under deep sedation or general anesthesia:

- Alternative behavioral guidance modalities
- Dental needs of the client
- The effect on the quality of dental care
- The client's emotional development
- The client's medical status

Conditions which qualify as meeting the criteria of medical necessity, include the following:

- Clients with a documented physical, mental or medically compromising condition
- Clients who have a dental need and for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy
- Clients who are extremely uncooperative, unmanageable, anxious or uncommunicative and who have dental needs deemed sufficiently urgent that care cannot be deferred. *Evidence of the attempt to manage in an outpatient setting must be provided*
- Clients who have sustained extensive orofacial and dental trauma
- Children with rampant decay

General anesthesia and deep sedation are contraindicated when the client is cooperative and requires minimal dental treatment, or when the client has a concomitant medical condition which would make general anesthesia or deep sedation unsafe.

If a dentist determines that a client needs hospitalization with or without associated general anesthesia, and meets one or more of the listed criteria, the dentist must:

1. Contact the client's HMO or medical management department for prior authorization to use the hospital. The HMO may require documentation of medical necessity; or
2. If the client is not enrolled in an HMO, the dentist should make prior arrangements with a hospital or ambulatory surgery center that is a participating Medicaid provider.

Check box number 38 (other) as the place of treatment on the 2006 ADA paper claim form, or bill electronically as an 837D transaction selecting either outpatient hospital or ambulatory surgery center as the place of treatment.

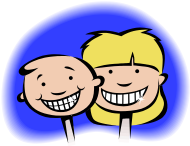
3. Bill any X-rays taken in either an outpatient hospital or ambulatory surgery center on the 2006 ADA claim for or electronically as an 837D transaction, line itemizing X-ray procedures with other dental procedures. Hospital outpatient departments and ambulatory surgery centers are not allowed to bill for additional CPT codes for dental X-rays performed during outpatient dental procedures.

Documentation

The dentist must retain sufficient information and diagnostic aids to clearly establish that the procedures are dentally and/or medically necessary. This information must be clearly documented in the client's dental records and furnished when requested by the dental consultant or other auditing entity. **Providers must accurately document all services rendered and justify medical necessity.**

Comprehensive Orthodontics

Comprehensive orthodontic treatment is available only to clients through age 20 that are Colorado Medical Assistance Program clients who qualify as having a severe handicapping malocclusion.



Only providers enrolled as dentists with an orthodontic specialty designation can submit PARs and provide orthodontic treatment of handicapping malocclusions. These PARs must include a 2010 "Handicapping Malocclusion Assessment" form and a completed 2006 ADA dental claim form.

Orthodontic PARs should be sent to Colorado Medical Assistance Program fiscal agent.

For a list of ADA orthodontic codes that are a benefit for clients through age 20 who qualify with a handicapping malocclusion, see the January 2010 Orthodontic Program Changes Provider Bulletin (B1000279).

Clients are no longer eligible for any orthodontic benefit once they reach age 21.

It is the responsibility of the orthodontic provider to contact the Department if the client terminates treatment prior to completion of the case for any reason.

Non-Covered Services

Non-covered services, except as described in the Billing Manual, for clients age 16 through age 20 from April 1, 2014 to June 30, 2014 include, but are not limited to, the following:

1. Cosmetic dentistry
2. Screening over age 20
3. Protective restorations
4. Full mouth debridement
5. Multiple units of crown and bridge. Single crowns only are covered for clients age 16 through age 20 from April 1, 2014 to June 30, 2014
6. Single crowns are not covered for cosmetic reasons; to restore vertical dimension; when the client has active and advanced periodontal disease; when the tooth is not in occlusion; or when there is evidence of periapical pathology
7. Periodontal surgery, other than gingivectomy for hyperplasia
8. Graft procedures
9. Endodontic surgery
10. Implants

11. Treatment for TMJ dysfunction; including diagnostic procedures
12. Biopsies are covered only when there is a specific suspicious lesion
13. Orthodontic treatment, unless prior approved with a documented handicapping malocclusion
14. Working and final treatment films for root canal treatment
15. Root canals for third molars
16. Root canals for second molars; unless the tooth is necessary to keep at least eight (8) posterior teeth in occlusion; or when the tooth is necessary to support a partial denture
17. Oral hygiene instruction
18. Removal of asymptomatic third molars
19. Any service that is not listed as covered

Treatment of the Oral Cavity for Clients Age 21 and Over with Concurrent Medical Condition(s)

From April 1, 2014 to June 30, 2014, more comprehensive and extensive treatment of the oral cavity for clients age 21 and older with allowable concurrent medical condition(s) will continue as listed in the February 2011 Dental Program Policy and Billing (B1100297) Provider Bulletin. Once all Medicaid-enrolled adults (age 21 and over) have access to the full Medicaid dental benefit July 1, 2014, the concurrent medical condition benefit for adults (age 21 and over) listed here will no longer be necessary.

Providers must document the presence of the concurrent medical condition that may worsen as a result of an existing oral cavity condition.

From April 1, 2014 to June 30, 2014, the following conditions apply to adult clients ages 21 and over with concurrent medical conditions:

1. Only certain concurrent or chronic medical conditions listed are exacerbated by a condition of the oral cavity, as documented by the dentist, qualify an adult client (aged 21 and older) for dental services.
2. PARs must be obtained prior to rendering services. Approval is not a guarantee of payment. Providers must wait to submit claims until they receive a PAR letter. Do not submit radiographs with a PAR unless requested by the dental consultant.

*Please refer to the codi*ng reference guide in the February 2011 Dental ADA Codes (B1100297) Provider Bulletin for procedural codes and PAR requirements for clients age 21 and older with concurrent or chronic medical conditions.

Documentation requirements for a PAR of non-emergency dental services provided to an adult dental client include:

- Client's primary dental complaint on the date of the dental visit.
- Medical and dental history resulting in the medical and dental condition of the client.
- Description of the results of all dental evaluation, radiographic and other diagnostic procedures rendered to the client.
- A copy of the signed and dated **physician's** memorandum requested for prior authorization review of another severe concurrent medical condition.
- The reviewing agent does not return the paper PAR or attachments with procedure approvals or denials to the providers.

Dental Services for Non-Citizens

Dental services for non-citizens are limited to emergency treatment of the oral cavity. No other dental services are a benefit for non-citizens under any circumstances. Refer to the above section noting Emergency Services.

Direct Access/Independent Dental Hygiene Providers

Dental procedures may be billed by an independent dental hygienist within their scope of practice, as defined by the Colorado Department of Regulatory Agencies (DORA).

The Colorado State Board of Dental Examiners sets and defines standards for safe dental practices and enforce standards for those who practice. Requirements for dental licensure are outlined in the Dental Practice Act, specifically 12-35-117, 12-35-119, and 12-35-120; Board Rule III, Licensure of Dentists and Dental Hygienists. The Dental Practice Act and Board rules are available on DORA's website→ Professions→ Dentists or Dental Hygienist.

In order to provide continuity of care, dental hygienists who are directly reimbursed must identify and document in the client's treatment record the Medicaid- participating dentist to which they refer clients.

Limitations for Direct Access/Independent Dental Hygienists

Dental hygienists employed by a dentist, clinic or institution cannot submit claims directly to the Colorado Medical Assistance Program. Claims must be submitted using the employer's Colorado Medical Assistance provider number.

An unsupervised dental hygienist cannot provide and bill dental services for a Medicaid non-citizen client of any age.

Effective April 1, 2014, Medicaid enrolled unsupervised or direct access dental hygienists (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D0120	Periodic oral evaluation-established patient
D0140	Limited oral evaluation - problem focused, established patient
D0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver
D0180	Comprehensive periodontal evaluation– new or established patient.
D0190	Screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis. One (1) every fiscal year after age five (5).
D0210	Intraoral - complete film series
D0220	Intraoral - periapical first film
D0230	Intraoral - periapical each additional film
D0240	Intraoral - occlusal film
D0270	Bitewing – single (1) film
D0272	Bitewings – two (2) films
D0274	Bitewings – four (4) films
D0277	Vertical Bitewings – seven (7) to eight (8) radiographic images
D0330	Panoramic radiographic image
D0999	Unspecified diagnostic procedure- For screening and assessment purposes only. This code will only be open April 1, 2014 to June 30, 2014.
D1110	Prophylaxis – adult, ages twelve (12) years and older
D1120	Prophylaxis – child

Effective April 1, 2014, Medicaid enrolled unsupervised or direct access dental hygienists (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D1203	Topical application of fluoride-child, ages (6) and older
D1204	Topical application of fluoride-adult, ages twelve (12) and older
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients Ages 0 through 20. Fluoride varnish is the only acceptable fluoride treatment that will be reimbursed by Medicaid for clients under age 6. Risk assessments must be included as part of the procedure.
D1351	Sealant (per tooth- benefit only for the occlusal surface of permanent molar teeth Tooth numbers # 2,3,14,15,18,19,30,31
Periodontal scaling and root planing will not available April 1, 2014 to June 30, 2014. Adult dental services (age 21 and over) that require a prior authorization must wait until July 1, 2014.	
D4341	Periodontal Scaling and root planing – four or more teeth per quadrant
D4342	Periodontal Scaling and root planing – one to three teeth per quadrant
D4910	Periodontal Maintenance

Assistant Surgeon

The **ASSIST** next to ADA codes in the February 2011 Provider Bulletin (B1100297) indicates procedures that allow for an assistant surgeon. Claims for dental assistant surgery must be submitted on the paper 2006 ADA claim form with the Dental Provider Certification form and the Assistant Surgeon Report attached. The Assistant Surgeon Report and the certification form are included in this manual and are available in the Provider Services Forms section of the Department's website.
http://www.chcpf.state.co.us/ACS/Provider_Services/Forms/Forms.asp
http://www.chcpf.state.co.us/ACS/Provider_Services/Forms/Forms.asp

- A PAR is not required for assistant surgeon services.
- Bill one (1) unit for ADA code D7999 "Unspecified oral surgery procedure, by report", and enter your total charge for assisting with the surgery/surgeries.
- In the "Remarks for unusual services" write "Assistant Surgery – See attached Report"
- Copy and complete the Assistant Surgeon Report. Attach it to your paper claim with the Dental Certification.

The Assistant Surgeon Report must be completed and submitted with the paper claim form and the certification form for all dental assistant surgery procedures.

Colorado Medicaid Program Billing

Assistant Surgeon Report

ASSIST next to the procedure code in the February 2011 Provider Bulletin (B1100297) indicates an assistant surgeon is allowed. The procedures for which an assistant surgeon is allowed are different for children, adults (age 21 and over), and non-citizen clients. Please refer to the appropriate section of the current Dental bulletin before providing these services.

- Prior authorization review (PAR) is **not** required for the assistant surgeon.
- Assistant surgeon claim must be submitted on a paper 2006 ADA claim form.
- Bill one (1) D7999 "unspecified oral surgery procedure, by report", and enter your total charge for assisting with the surgery/surgeries.
- In the "Remarks" area, write "assistant surgery."
- Please do not send x-rays.

Copy this page, complete the Assistant Surgeon Report, and attach it to your paper claim form.

If enrolled in Medicaid as a dentist rather than physician, CPT medical and surgical codes cannot be used.

Assistant Surgeon Report

Report date _____

Assistant surgeon name _____

Medicaid Program provider number _____ **Provider NPI** _____

Primary surgeon name _____

Medicaid Program provider number _____ **Provider NPI** _____

Medicaid Program client name _____ **Client Medicaid ID number** _____

Claim date of service _____

List the ADA procedure codes provided by the primary surgeon, for which you were the assistant surgeon.

Attach this form to completed ADA claim form as described on the previous page.

PLEASE COPY THIS BLANK FORM AS NEEDED

Dental Assistant Surgeon form (12/08)

2006 ADA Paper Claim Instructional Reference

Header Information

Field Label	Completion Format	Instructions
1. Type of Transaction **Statement of Actual Services** Required	Check Box ☐	(✓) Check **Statement of Actual Services** for Claims for payment. **Submit PARs and claims on separate forms.**
1. Type of Transaction **Request for Predetermination** Required	Check Box ☐	(✓) Check **Request for Predetermination** for Prior Authorization Requests (PARs). **Submit PARs and claims on separate forms.**
1. Type of Transaction **EPSDT/Title XIX** Required	Check Box ☐	(✓) Check when the client is age 20 or under on date of service. The client must also be 20 or under at the time the PAR is approved.
2. Predetermination / Preauthorization Number Conditional	7 Characters	Complete if the Colorado Medical Assistance Program Fiscal Agent Dental Consultant has issued a prior authorization number. Example: C223344

Insurance Company/Dental Benefit Plan Information

Field Label	Completion Format	Instructions
3. Company/Plan Name, Address, City, State, Zip Code Required	Text	If the client has dental insurance coverage, enter the information for that primary payer. If **no other** dental insurance then submit PARs electronically to the ColoradoPAR Program through CWQI.

Other Coverage

Field Label	Completion Format	Instructions
4. Other Dental or Medical Coverage Conditional	Check Box ☐	Complete if the client has **commercial dental** insurance. (✓) Check Yes or No. If Yes, complete 5 through 11. If No, skip 5 through 11.
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) Conditional	Text	Complete if the client has **commercial dental** insurance coverage. Enter the name of the primary policy holder.
6. Date of Birth (MM/DD/YYYY) Conditional	8 Digits	Complete if the client has **commercial dental** insurance coverage. Enter the policyholder's birth date. Two Digits for the month Two Digits for the date Four Digits for the year Example: 01/01/2010 for January 1, 2010
7. Gender Conditional	Check Box ☐	Complete if the client has **commercial dental** insurance. (✓) Check to indicate the policyholder's sex.
8. Policyholder/Subscriber ID (SSN or ID#) Conditional	Characters	Complete if the client has **commercial dental** insurance coverage. Enter the primary policy holder's ID number.
9. Plan/Group Number Conditional	Characters	Complete if the client has **commercial dental** insurance coverage. Enter the group number of the commercial dental insurance plan.
10. Patient's Relationship to Person Named in #5 Conditional	Check Box ☐	Complete if the client has **commercial dental** insurance. Check the patient's relationship to the primary policy holder. (✓) Check ▪ Self ▪ Dependent ▪ Spouse ▪ Other

Field Label	Completion Format	Instructions
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code Conditional	Text	Complete if the client has **commercial dental** insurance. Enter the name and address of the commercial dental insurance plan.

Policyholder/Subscriber Information (For Insurance Company Named in #3)

Field Label	Completion Format	Instructions
12. Policyholder/Subscriber Name, Address, City, State, Zip Code Required		Enter client's name and address. Last First Middle Initial Suffix Address, City, State, Zip Code
13. Date of Birth DD/MM/YYYY Required	8 Digits	Use the birth date that appears on the eligibility verification response. Two Digits for the month Two Digits for the day Four Digits for the year Example: 11/01/2007 for November 1, 2007
14. Gender Required	Check Box ☐	(✓) Check to indicate the client's sex.
15. Policyholder/Subscriber ID Required	7 Characters	A letter prefix followed by six numbers. Enter the client's **Medicaid Program ID** number exactly as it appears on the eligibility verification response. Example: A123456
16. Plan/Group Number Not required		Submitted information is not entered into the claim processing system.
17. Employer Name Not required		Submitted information is not entered into the claim processing system.

Patient Information

Field Label	Completion Format	Instructions
18. Patient Relationship to Policyholder/Subscriber Required	Check Box "Self" ☐	Marked the box titled "Self" and skip to item #23
19. Student Status Not required		Submitted information is not entered into the claim processing system.
20. Name, Address, City, State, Zip Code Not Required		Submitted information is not submitted into the claim processing system
21. Date of Birth Not required		Submitted information is not submitted into the claim processing system
22. Gender Not required		Submitted information is not submitted into the claim processing system
23. Patient ID/Account # Not Required		Enter if the dentist's office has assigned an internal number to identify the patient.

Record of Services Provided

Field Label	Completion Format	Instructions
24. Procedure Date (MM/DD/YYYY) Conditional	8 Digits	**PARs:** Do not enter a date **Claims :** Enter date that service was performed Two Digits for the month Two Digits for the day Four Digits for the year Example: 01/01/2010 for January 1, 2010.
25. Area of Oral Cavity Not required		Submitted information is not entered into the claim processing system.

Field Label	Completion Format	Instructions
26. Tooth System Not required		Submitted information is not entered into the claim processing system.
27. Tooth Number(s) or Letter(s) Conditional	Characters	Enter the tooth number(s) using one line for each tooth.
28. Tooth Surface Conditional	Letters	Enter the tooth surface(s) for each tooth when treatment is for a restoration. Do not enter tooth surfaces for crowns.
29. Procedure Code Required	5 Characters	ADA dental codes only. **CPT medical and surgical codes cannot be used.**
30. Description Required	Text	Enter a description of the service for each ADA procedure code. Example: amalgam -1 surface Example: resin based composite – 2 surfaces
31. Fee Required	Currency	Usual and customary charge for the procedure.
32. Other Fee(s) Not required		Submitted information is not entered into the claim processing system.
33. Total Fee Required	Currency	Enter the total of all fees.

Missing Teeth Information

Field Label	Completion Format	Instructions
34. (Place an "X" on each missing tooth) Not required		Submitted information is not entered into the claim processing system.

Field Label	Completion Format	Instructions
35. Remarks Conditional	Text	**Child PARs** Describe dental necessity for the procedure. Enter any additional information that may be needed for prior authorization review. **Adult PARs** Describe dental necessity for the procedure & **concurrent medical condition**. Enter any additional information that may be needed for prior authorization review. **Claims** Enter any comments that may assist processing of the claim. You may attach a separate sheet of paper to the claim if you need more space.

Authorizations

Field Label	Completion Format	Instructions
36. Patient/Guardian Signature and Date Not required		Submitted information is not entered into the claim processing system.
37. Subscriber Signature and Date Not required		Submitted information is not entered into the claim processing system.

Ancillary Claim/Treatment Information

Field Label	Completion Format	Instructions
38. Place of Treatment Required	Check Box ☐	(✓) Check the appropriate place of treatment. ☑ Office ☑ Hospital ☑ Extended Care Facility (ECF) ☑ Other

Field Label	Completion Format	Instructions
39. Number of Enclosures Conditional	Check Box ☐	(✓) Check the box and use this field if radiographs, other images or models have been requested by the dental consultant and are being sent with this form. Otherwise leave blank. If radiographs, images or models have been requested, label them with the patient's name and Colorado Medical Assistance Program ID number as well as name of the provider.
40. Is Treatment for Orthodontics? Conditional	Check Box ☐	(✓) Check the box if requesting prior authorization for orthodontic services. If "Yes" is checked, complete field numbers 41-42. If "No" skip 41-42.
41. Date Appliance Placed (MM/DD/YYYY) Conditional	8 Digits	If orthodontic treatment has commenced, enter the date that the appliance was placed. Two Digits for the month Two Digits for the date Four Digits for the year Example: 01/01/2010 for January 1, 2010
42. Months of Treatment Remaining Conditional	Characters	For orthodontic services only. If orthodontic treatment has commenced, enter the number of months of treatment remaining.
43. Replacement of Prosthesis? Conditional	Check Box ☐	If requesting prior authorization for prosthesis. (✓) Check Yes or No. If "Yes" complete 44.
44. Date Prior Placement (MM/DD/YYYY) Conditional	8 Digits	If requesting prior authorization for prosthesis, enter date of prior placement. Two Digits for the month Two Digits for the day Four Digits for the year Example: 01/01/2010 for January 1, 2010
45. Treatment Resulting From Conditional	Check Box ☐	(✓) Check box if applicable. If "accident" is checked then complete 46. If not then skip to field 48.

Field Label	Completion Format	Instructions
46. Date of Accident (MM/DD/YYYY) Conditional	8 Digits	Enter the date of accident. Two Digits for the month Two Digits for the date Four Digits for the year Example: 01/01/2010 for January 1, 2010.
47. Auto Accident State Conditional	Text	Enter the State in which the auto accident occurred.

Billing Dentist or Dental Entity

Field Label	Completion Format	Instructions
48. Name, Address, City, State Zip Code Required	Text	Enter the name and address of the billing dentist/group submitting the claim.
49. Billing Dentist NPI Conditional	10 Digits	Enter the 10 digit National Provider Identification (NPI) number assigned to the billing dentist. Payment is made to the enrolled provider or agency that is assigned this number. Example: 9876543210
50. License Number Optional		Submitted information is not entered into the claim processing system.
51. SSN or TIN Not required		Submitted information is not entered into the claim processing system.
52. Phone Number Required	10 Digits	Include area code with phone number.
52A. Billing Dentist Provider ID Number Required	8 Digits	Enter the eight-digit Medicaid Program provider number assigned to the **billing dentist**. Payment is made to the enrolled provider or agency that is assigned this number. Example: 98765432

Treating Dentist and Treatment Location Information

Field Label	Completion Format	Instructions
53. Treating Dentist (Provider) Signature and Date Conditional		**PAR:** Prior Authorization Requests do not need to be signed **Claim:** Sign dental claims when payment is requested. **Claim Signature Requirements:** Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. **Unacceptable signature alternatives:** ▪ Claim preparation personnel may not sign the enrolled provider's name. ▪ Initials or block printing are not acceptable as a signature. ▪ Typed or computer printed names are not acceptable as a signature. ▪ "Signature on file" notation is not acceptable in place of an authorized signature.
54. Treating provider NPI Conditional	10 Digits	Enter the 10 digit National Provider Identification number assigned to the **treating** dentist. Example: 9876543210
55. License Number Optional		Submitted information is not entered into the claim processing system.
56. Address, City, State, Zip Code Required	Text	Enter the treating dentist's address.

Field Label	Completion Format	Instructions
56A. Provider Specialty Code Conditional	Characters	If the treating dentist is enrolled in Colorado Medical Assistance Program with a dental specialty designation, enter it here.
57. Phone Number Required	10 Digits	Include area code with phone number
58. Additional Provider ID Required	8 digits	Enter the eight-digit Medicaid Program provider number assigned to the **treating dentist**. Example: 23456789

Coverage Policies and Procedure Code Table

This section describes the Colorado Medical Assistance Program policies for dental benefit coverage for the following populations: adults (age 21 years and over). Please refer to the American Dental Association (ADA) publication Current Dental Terminology (CDT) 2013 for detailed code information, clarification, and appropriate code selection.

Procedure Code Table for the Adult Dental Benefits (For services rendered on or after April 1, 2014)

D0100-D0999 I. Diagnostic

Clinical Oral Evaluations

D0120	periodic oral evaluation – established patient
D0140	limited oral evaluation – problem focused
D0150	comprehensive oral evaluation – new or established patient
D0180	comprehensive periodontal evaluation – new or established patient

Radiographs/Diagnostic Imaging (Including Interpretation)

D0210	intraoral – complete series of radiographic image
D0220	intraoral – periapical first radiographic image
D0230	intraoral – periapical each additional radiographic image
D0270	dental bitewing – single radiographic image
D0272	dental bitewings – two radiographic images
D0274	dental bitewings – four radiographic images
D0277	vertical bitewings – 7 to 8 radiographic images
D0330	panoramic radiographic image
→ limited to clients age 6 years or older	

Tests and Examinations

D0460	pulp vitality tests
→ includes multiple teeth & contra lateral comparison/s	

D1000-D1999 II. Preventive

Dental Prophylaxis

D1110	prophylaxis – adult
→ limited to twice annually; limited to clients age 12 years or older	

D2000-D2999 III. Restorative

Amalgam Restorations (Including Polishing)

D2140	amalgam – one surface, primary or permanent
D2150	amalgam – two surfaces, primary or permanent
D2160	amalgam – three surfaces, primary or permanent
D2161	amalgam – four or more surfaces, primary or permanent

Resin-Based Composite Restorations – Direct

D2330	resin-based composite – one surface, anterior
D2331	resin-based composite – two surfaces, anterior
D2332	resin-based composite – three surfaces, anterior
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391	resin-based composite – one surface, posterior
D2392	resin-based composite – two surfaces, posterior
D2393	resin-based composite – three surfaces, posterior
D2394	resin-based composite – four or more surfaces, posterior

D7000-D7999 IV. Oral and Maxillofacial Surgery

Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)

D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)

D7250	surgical removal of residual tooth roots (cutting procedure)

Surgical Incision

D7510	incision & drainage of abscess – intraoral soft tissue
D7511	incision & drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7520	incision & drainage of abscess – extraoral soft tissue

D9000-D9999 V. Adjunctive General Services

Unclassified Treatment

D9110	palliative (emergency) treatment of dental pain – minor procedure
→ This code can only be billed for minor dental procedures to relieve dental pain in emergencies. The nature of the emergency and the specific treatment provided must be documented in the patient's chart. This code may not be used for writing prescriptions dispensing medications in the office, or administering drugs orally. It may be used in conjunction with a problem focused examination code, radiographs, and other diagnostic procedures needed to support diagnosis prior to performance of the palliative treatment.	

Professional Visits

D9410	house/extended care facility call

HCPCS Code Table

▲- Description change (please refer to the CDT 2013 manual)

Code Table for Children's Benefits

D0100-D0999 I. Diagnostic

Clinical Oral Evaluations	
D0120	periodic oral evaluation
D0140	limited oral evaluation - problem focused
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	comprehensive oral evaluation - new or established patient
D0160	detailed & extensive oral evaluation - problem focused, by report
D0170	evaluation-limited, problem focused (established patient; not post-operative visit)
D0180	comprehensive periodontal evaluation- new or established patient
D0190	Screening of a patient
D0191	Assessment of a patient
→ limited to independent hygienists only and clients ages 15-20 only	

Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	intraoral - complete series (including bite wings)
D0220	intraoral - periapical first film
D0230	intraoral – periapical each additional film
D0240	intraoral - occlusal film
→ limit is 2 per date of service	
D0250	extraoral - first film
D0260	extraoral - each additional film
D0270	bitewing - single film
D0272	bitewings - two films
D0274	bitewings - four films
D0277	vertical bitewings – 7 to 8 films
D0290	posterior-anterior or lateral skull & facial bone survey film
D0310	sialography
D0320	temporomandibular joint arthrogram, including injection
D0321	other temporomandibular joint films, by report
D0322	tomographic survey
D0330	panoramic film
→ limited to ages 6 through 20	
D0340	cephalometric film
D0350	oral/facial photographic images
D0364	screening of a patient
D0365	assessment of a patient
D0366	cone beam CT capture and interpretation with limited field of view- less than one whole jaw
D0367	cone beam CT capture and interpretation with field of view of one full dental arch-mandible
D0381	cone beam CT capture and interpretation with field of view of one full dental arch-mandible
D0382	cone beam CT capture and interpretation with limited field of view- less than one whole jaw

Tests and Examinations	
D0415	collection of microorganisms for culture and sensitivity
D0425	caries susceptibility tests
→ not to be used for carious dentin staining	
→ for in-office lab culture, the provider must be CLIA certified (ages 0-5 years)	
D0460	pulp vitality tests
→ includes multiple teeth & contra lateral comparison/s	
D0470	diagnostic casts
→ includes both maxillary and mandibular casts Do not send to the fiscal agent unless requested to do so by the ColoradoPAR Program dental consultant.	
D0999	PAR unspecified diagnostic procedure, by report
→ used only by dental hygienists for dental screening and assessment purposes only. This code will only be open April 1, 2014 to June 30, 2014.	
→ dentists can use code D7999 or D9999 for unusual diagnostic service	

D1000-D1999 II. Preventive

Dental Prophylaxis	
D1110	prophylaxis, adult
→ limited to twice annually	
D1120	prophylaxis, child
→ limited to twice annually	

Topical Fluoride Treatment	
▲D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patient
→ Varnish is the only acceptable fluoride treatment for ages 6 and under Risk assessment form for dental personnel is Attachment D Risk assessment form for medical personnel is Attachment E	

Other Preventive Services	
D1351	sealant - per tooth
→ a benefit only for permanent molars	
→ mechanically and/or chemically prepared enamel surface sealed to prevent decay	
D1352	preventive resin restoration in a moderate to high caries risk patient- permanent tooth
→ conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into the dentin; applicable to tooth surfaces O, OL, OB, B and L; limited to tooth numbers 2, 3, 14, 15, 18, 19, 30, 31.	

Space Maintainers (Passive Appliances)	
D1510	space maintainer - fixed - unilateral
D1515	space maintainer - fixed - bilateral
D1520	space maintainer - removable - unilateral
D1525	space maintainer - removable - bilateral
D1550	recementation of space maintainer
D1555	removal of fixed space maintainer

D2000-D2999 III. Restorative

Amalgam Restorations (Including Polishing)	
D2140	amalgam - one surface, primary or permanent
D2150	amalgam - two surfaces, primary or permanent

D2160	amalgam - three surfaces, primary or permanent
D2161	amalgam - four or more surfaces, primary or permanent

Resin-Based Composite Restorations-Direct	
D2330	resin-based composite - one surface, anterior
D2331	resin-based composite - two surfaces, anterior
D2332	resin-based composite - three surfaces, anterior
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2391	resin-based composite – one surface, posterior
D2392	resin-based composite – two surfaces, posterior
D2393	resin-based composite – three surfaces, posterior
D2394	resin-based composite – four or more surfaces, posterior
Crowns - Single Restorations Only	
D2751	PAR crown - porcelain fused to predominately base metal
→ a benefit for teeth 1-32	
D2791	PAR crown - full cast predominantly base metal
→ a benefit for teeth 1-32	

Other Restorative Services	
D2910	recement inlay, onlay or partial coverage restoration
D2920	recement crown
D2930	prefabricated stainless steel crown - primary tooth
D2931	prefabricated stainless steel crown - permanent tooth
D2932	prefabricated resin crown
→ benefit only for primary anteriors	
→ limited to teeth C-H, M-R	
D2933	prefabricated stainless steel crown with resin window
→ benefit only for primary anteriors	
→ limited to teeth C-H, M-R	
D2934	prefabricated esthetic coated stainless steel crown – primary tooth
→ benefit only for primary anteriors	
→ limited to teeth C-H, M-R	
D2940	protective restoration
D2950	core build up, including any pins
D2951	pin retention - per tooth, in addition to restoration
D2952	PAR post and core in addition to crown, indirectly fabricated
D2953	PAR each additional indirectly fabricated post – same tooth
D2954	prefabricated post and core in addition to crown
▲D2955	post removal (not in conjunction with endodontic therapy)
D2957	each additional prefabricated post – same tooth
▲D2980	PAR crown repair, by report
D2999	PAR unspecified restorative procedure, by report

D3000-D3999 IV. Endodontics

Pulp Capping	
D3110	pulp cap - direct (excluding final restoration)
D3120	pulp cap - indirect (excluding final restoration)

Pulpotomy	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament

Pulpotomy	
D3221	pulpal debridement, primary and permanent teeth
→ a benefit for teeth 1-32 only	
→ gross pulpal debridement for the relief of acute pain prior to conventional root canal therapy	
→ not to be used by the provider completing endodontic treatment	
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
→ a benefit for permanent tooth numbers 2-15, 18-31	

Endodontic Therapy on Primary Teeth	
D3230	pulp therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)
→ limited to teeth C-H, M-R	
D3240	pulp therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
→ limited to teeth A, B, I, J, K, L, S, T	

Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)	
D3310	endodontic therapy, anterior tooth (excluding final restoration)
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)
D3330	endodontic therapy, molar (excluding final restoration)
D3331	treatment of root canal obstruction; non-surgical access
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3333	internal root repair of perforation defects

Endodontic Retreatment	
D3346	retreatment of previous root canal therapy - anterior
D3347	retreatment of previous root canal therapy - bicuspid
D3348	retreatment of previous root canal therapy - molar

Apexification/Recalcification and Pulpal Regeneration Procedures	
D3351	apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3352	apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection,etc.)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)

Apicoectomy/Periradicular Services	
D3410	apicoectomy/periradicular surgery - anterior
D3421	apicoectomy/periradicular surgery - bicuspid (first root)
D3425	apicoectomy/periradicular surgery - molar (first root)
D3426	apicoectomy/periradicular surgery (each additional root)
D3430	retrograde filling - per root
D3450	root amputation - per root
D3460	PAR endodontic endosseous implant
D3470	PAR intentional reimplantation (including necessary splinting)

Other Endodontic Procedures	
D3910	surgical procedure for isolation of tooth with rubber dam
D3920	hemisection (including any root removal), not including root canal therapy
D3950	canal preparation and fitting of preformed dowel or post
D3999	PAR unspecified endodontic procedure, by report

D4000-D4999 V. Periodontics

Surgical Services (Including Usual Postoperative Care)	
▲D4210	PAR gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
▲D4211	PAR gingivectomy or gingivoplasty one to three contiguous teeth or tooth bounded spaces per quadrant
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240	PAR gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant
D4245	PAR apically positioned flap
D4249	PAR clinical crown lengthening - hard tissue
▲D4260	PAR osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
▲D4261	PAR osseous surgery (including flap entry and closure) one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263	PAR bone replacement graft - first site in quadrant
D4264	PAR bone replacement graft - each additional site in quadrant
D4266	PAR guided tissue regeneration - resorbable barrier, per site
D4267	PAR guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)
D4268	PAR surgical revision procedure, per tooth
D4270	PAR pedicle soft tissue graft procedure
D4273	PAR subepithelial connective tissue graft procedures, per tooth
D4274	PAR distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)
D4277	free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
D4278	free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site

Non-Surgical Periodontal Service	
D4320	provisional splinting - intracoronal
D4321	provisional splinting - extracoronal
D4341	PAR periodontal scaling and root planing - four or more teeth per quadrant
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis
→ Procedure D4355 is limited to ages 13-20 without pre-authorization. It is not an available code for children 12 and under. Prophylaxis (D1110 or D1120) or topical fluoride (D1203 or D1204) are not benefits when provided on the same day of service as D4355. Other D4000 series codes are not benefits when provided on the same date of service as D4355. If audited, the provider should be able to document through radiographs or photographs the need for D4355 and must also include a narrative.	
▲D4381	PAR localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report

Other Periodontal Services	
D4999	PAR unspecified periodontal procedure, by report

D5000-D5899 VI. Prosthodontics (removable)

Complete Dentures (Including Routine Post-Delivery Care)	
D5110	PAR complete denture - maxillary
D5120	PAR complete denture - mandibular

Complete Dentures (Including Routine Post-Delivery Care)	
D5130	PAR immediate denture - maxillary
D5140	PAR immediate denture - mandibular

Partial Dentures (Including Routine Post-delivery Care)	
D5211	PAR maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212	PAR mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213	PAR maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	PAR mandibular partial denture - casts metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5281	PAR removable unilateral partial denture - one piece cast metal (including clasps and teeth)

Adjustments to Dentures	
D5410	adjust complete denture - maxillary
D5411	adjust complete denture - mandibular
D5421	adjust partial denture - maxillary
D5422	adjust partial denture - mandibular

Repairs to Complete Dentures	
D5510	repair broken complete denture base
D5520	repair missing broken teeth - complete denture (each tooth)

Repairs to Partial Dentures	
D5610	repair resin denture base
D5620	repair cast framework
D5630	repair or replace broken clasp
D5640	replace broken teeth - per tooth
D5650	add tooth - to existing partial denture
D5660	add clasp to existing partial denture

Denture Rebase Procedures	
D5710	rebase complete maxillary denture
D5711	rebase complete mandibular denture
D5720	rebase maxillary partial denture
D5721	rebase mandibular partial denture

Denture Reline Procedures	
D5730	reline complete maxillary denture (chair side)
D5731	reline complete mandibular denture (chair side)
D5740	reline maxillary partial denture (chair side)
D5741	reline mandibular partial denture (chair side)
D5750	reline complete maxillary denture (laboratory)
D5751	reline complete mandibular denture (laboratory)
D5760	reline maxillary partial denture (laboratory)
D5761	reline mandibular partial denture (laboratory)

Interim Prosthesis	
D5810	PAR interim complete denture (maxillary)

Interim Prosthesis	
D5811	PAR interim complete denture (mandibular)
D5820	PAR interim partial denture (maxillary)
D5821	PAR interim partial denture (mandibular)

Other Removable Prosthetic Services	
D5850	tissue conditioning, maxillary
D5851	tissue conditioning, mandibular
D5862	PAR precision attachment, by report
D5867	PAR replacement of replaceable part of semi-precision or precision attachment (male or female component)
D5875	PAR modification of removable prosthesis following implant surgery
D5899	PAR unspecified removable prosthodontic procedure, by report

D5900-D5999 VII. Maxillofacial Prosthetics

Maxillofacial Prosthetics	
D5911	PAR facial moulage (sectional)
D5912	PAR facial moulage (complete)
D5913	PAR nasal prosthesis
D5914	PAR auricular prosthesis
D5915	PAR orbital prosthesis
D5916	PAR ocular prosthesis
D5919	PAR facial prosthesis
D5922	PAR nasal septal prosthesis
D5923	PAR ocular prosthesis, interim
D5924	PAR cranial prosthesis
D5925	PAR facial augmentation implant prosthesis
D5926	PAR nasal prosthesis, replacement
D5927	PAR auricular prosthesis, replacement
D5928	PAR orbital prosthesis, replacement
D5929	PAR facial prosthesis, replacement
D5931	PAR obturator prosthesis, surgical
D5932	PAR obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	PAR mandibular resection prosthesis with guide flange
D5935	PAR mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	PAR trismus appliance (not for TMD treatment)
D5951	PAR feeding aid
D5952	PAR speech aid prosthesis, pediatric
D5953	PAR speech aid prosthesis, adult
D5954	PAR palatial augmentation prosthesis
D5955	PAR palatial lift prosthesis, definitive
D5958	PAR palatial lift prosthesis, interim
D5959	PAR palatial lift prosthesis, modification
D5960	PAR speech aid prosthesis, modification
D5982	surgical stent
D5983	PAR radiation carrier
D5984	PAR radiation shield
D5985	PAR radiation cone locator
D5986	PAR fluoride gel carrier

Maxillofacial Prosthetics	
D5987	PAR commissure splint
D5988	surgical splint
D5991	topical medicament carrier
D5992	adjust maxillofacial prosthetic appliance, by report
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
D5999	PAR unspecified maxillofacial prosthesis, by report

D6000-D6199 VIII. Implant Services

Local anesthesia is usually considered to be part of Implant Services procedures.

Pre-Surgical Services Report surgical implant procedure using codes in this section.	
D6190	PAR radiographic/surgical implant index, by report

Surgical Services Report surgical implant procedure using codes in this section.	
D6010	PAR surgical placement of implant body: endosteal implant
D6040	PAR surgical placement: eposteal implant
D6050	PAR surgical placement: transosteal implant

Implant Supported Prosthetics Supporting Structures	
D6055	PAR dental implant supported connecting bar
▲D6056	PAR prefabricated abutment, includes placement
▲D6057	PAR custom abutment, includes placement

Single Crowns, Abutment Supported	
D6060	PAR abutment supported porcelain fused to metal crown (predominantly base metal)
D6063	PAR abutment supported cast metal crown (predominantly base metal)

Fixed Partial Denture, Abutment Supported	
D6070	PAR abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6073	PAR abutment supported retainer for cast metal FPD (predominantly base metal)

Other Implant Services	
D6080	PAR implant maintenance procedures, including removal of prosthesis, cleaning of prosthesis and abutments, reinsertion of prosthesis
D6090	PAR repair implant supported prosthesis, by report
D6092	recement implant/abutment supported crown
D6093	recement implant/abutment supported fixed partial denture
D6095	PAR repair implant abutment, by report
D6199	PAR unspecified implant removal procedure, by report

D6200-D6999 IX. Prosthodontics, fixed

Fixed Partial Denture Pontics	
D6211	PAR pontic - cast predominately base metal
→ a benefit for teeth 1-32	

Fixed Partial Denture Pontics	
D6241	PAR pontic - porcelain fused to predominantly base metal
→ a benefit for teeth 1-32	

Fixed Partial Denture Retainers - Inlays/Onlays	
D6545	PAR retainer - cast metal for resin bonded fixed prosthesis
→ a benefit only for teeth 6-11, 22-27	

Fixed Partial Denture Retainers - Crowns	
D6751	PAR crown – porcelain fused to predominantly base metal
→ a benefit for teeth 1-32	
D6791	PAR crown - full cast predominantly base metal
→ a benefit only for teeth 1-32	

Other Fixed Partial Denture Services	
D6920	PAR connector bar
D6930	recement fixed partial denture
D6940	PAR stress breaker
D6950	PAR precision attachment
▲D6975	PAR coping – metal
▲D6980	PAR fixed partial denture repair, by report
D6999	PAR unspecified fixed prosthodontic procedure, by report
→ code valid for tooth numbers 1-32 only	

D7000-D7999 X. Oral and Maxillofacial Surgery

Local anesthesia is usually considered to be part of Oral and Maxillofacial Surgical procedures.
For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and/or teeth spaces distal to the midline.

Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	removal of impacted tooth - soft tissue
D7230	removal of impacted tooth - partially bony
D7240	removal of impacted tooth - completely bony
D7241	removal of impacted tooth - completely bony, with unusual surgical complications
D7250	surgical removal of residual tooth roots (cutting procedure)
D7251	coronectomy –intentional partial tooth removal

Other Surgical Procedures	
D7260	oral antral fistula closure
D7261	primary closure of sinus perforation
D7270	tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7272	tooth transplantation (includes reimplantation from one site to another and splinting &/or stabilization)
D7280	PAR surgical access of an unerupted tooth
	An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.

Other Surgical Procedures	
D7283	PAR placement of device to facilitate eruption of impacted tooth
→ placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption: not for placement of inter-dental wire ligatures; not for brass wire eruption spacer. Report surgical exposure separately using D7280	
D7285	biopsy of oral tissue, hard (bone, tooth)
D7286	biopsy of oral tissue, soft
D7288	brush biopsy – transepithelial sample collection
D7290	surgical repositioning of teeth
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report
D7295	PAR ASSIST harvest of bone for use in autogenous grafting procedure

Alveoloplasty - Surgical Preparation of Ridge	
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant

Vestibuloplasty	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied & hyperplastic tissue)

Surgical Excision of Soft Tissue Lesions	
D7410	excision of benign lesion up to 1.25 cm
D7411	ASSIST excision of benign lesion greater than 1.25 cm
D7412	ASSIST excision of benign lesion, complicated
D7413	ASSIST excision of malignant lesion up to 1.25 cm
D7414	ASSIST excision of malignant lesion greater than 1.25 cm
D7415	ASSIST excision of malignant lesion, complicated

Surgical Excision of Intra-Osseous lesions	
D7440	excision of malignant tumor - lesion diameter up to 1.25cm
D7441	ASSIST excision of malignant tumor - lesion diameter greater than 1.25cm
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25cm
D7451	ASSIST removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25cm
D7461	ASSIST removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7465	destruction of lesions(s) by physical or chemical methods, by report

Excision of Bone Tissue	
D7471	removal of lateral exostosis (maxilla or mandible)
D7472	removal of torus palatinus
D7473	removal of torus mandibularis
D7485	surgical reduction of osseous tuberosity
D7490	radical resection of maxilla or mandible

Surgical Incision	
D7510	incision & drainage of abscess - intraoral soft tissue
D7511	ASSIST incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

Surgical Incision	
D7520	incision & drainage of abscess - extraoral soft tissue
D7521	ASSIST incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple facial spaces)
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	removal of reaction-producing foreign bodies, musculoskeletal system
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of Fractures - Simple	
D7610	maxilla - open reduction (teeth immobilized, if present)
D7620	maxilla - closed reduction (teeth immobilized, if present)
D7630	mandible - open reduction (teeth immobilized, if present)
D7640	mandible - closed reduction (teeth immobilized, if resent)
D7650	malar &/or zygomatic arch - open reduction
D7660	malar &/or zygomatic arch - closed reduction
D7670	alveolus – closed reduction, may include stabilization of teeth
D7671	alveolus – open reduction, may include stabilization of teeth
D7680	facial bones - complicated reduction with fixation & multiple surgical approaches

Treatment of Fractures - Compound	
D7710	ASSIST maxilla - open reduction
D7720	ASSIST maxilla - closed reduction
D7730	ASSIST mandible - open reduction
D7740	ASSIST mandible - closed reduction
D7750	ASSIST malar and/or zygomatic arch - open reduction
D7760	ASSIST malar and/or zygomatic arch - closed reduction
D7770	ASSIST alveolus - open reduction stabilization of teeth
D7771	alveolus – closed reduction stabilization of teeth
D7780	ASSIST facial bones - complicated reduction with fixation & multiple surgical approaches

Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions	
D7810	open reduction of dislocation
D7820	closed reduction of dislocation
D7830	manipulation under anesthesia
D7840	PAR ASSIST condylectomy
D7850	PAR ASSIST surgical discectomy, with/without implant
D7852	PAR ASSIST disc repair
D7854	PAR ASSIST synovectomy
D7856	PAR ASSIST myotomy
D7858	PAR ASSIST joint reconstruction
D7860	PAR ASSIST arthrotomy
D7865	PAR ASSIST arthroplasty
D7870	PAR ASSIST arthrocentesis
D7871	PAR ASSIST non-arthroscopic lysis and lavage
D7872	PAR ASSIST arthroscopy – diagnostic, with or without biopsy
D7873	PAR ASSIST arthroscopy - surgical: lavage & lysis of adhesions
D7874	PAR ASSIST arthroscopy - surgical: disc repositioning & stabilization
D7875	PAR ASSIST arthroscopy - surgical: synovectomy
D7876	PAR ASSIST arthroscopy - surgical: discectomy
D7877	PAR ASSIST arthroscopy - surgical: debridement

Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions	
D7880	PAR occlusal orthotic device, by report
D7899	PAR ASSIST unspecified TMD therapy, by report

Repair of Traumatic Wounds	
D7910	suture of recent small wounds - up to 5 cm

Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)	
D7911	complicated suture - up to 5 cm
D7912	complicated suture - greater than 5 cm

Other Repair Procedures	
D7920	ASSIST skin graft (identify defect covered, location and type of graft)
D7940	PAR ASSIST osteoplasty - for orthognathic deformities
D7941	PAR ASSIST osteotomy – mandibular rami
D7943	PAR ASSIST osteotomy – mandibular rami with bone graft; includes obtaining the graft
D7944	PAR ASSIST osteotomy - segmented or subapical
D7945	PAR ASSIST osteotomy - body of mandible
D7946	PAR ASSIST Lefort I (maxilla - total)
D7947	PAR ASSIST Lefort I (maxilla - segmented)
D7948	PAR ASSIST Lefort II or Lefort III (osteoplasty of facial bones for mid-face hypoplasia or retrusion) - without bone graft
D7949	PAR ASSIST Lefort II or Lefort III - with bone graft
D7950	PAR ASSIST osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
▲D7951	PAR sinus augmentation with bone or bone substitutes (age 12-20 years)
D7955	PAR ASSIST repair of maxillofacial soft and/or hard tissue defect
D7960	frenulectomy – also known as frenectomy or frenotomy - separate procedure not incidental to another
D7963	frenuloplasty
D7970	excision of hyperplastic tissue - per arch
D7971	excision of pericoronal gingiva
D7972	surgical reduction of fibrous tuberosity
D7980	sialolithotomy
D7981	ASSIST excision of salivary gland, by report
D7982	sialodochoplasty
D7983	closure of salivary fistula
D7990	emergency tracheotomy
D7991	PAR ASSIST coronoidectomy
D7995	PAR ASSIST synthetic graft - mandible or facial bones, by report
D7996	PAR ASSIST implant - mandible for augmentation purposes (excluding alveolar), by report
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	PAR ASSIST unspecified oral surgery procedure, by report

Benefits for Adults

The services for Medicaid clients who are adults, ages 21 and older, are limited to (1) emergency treatment and (2) treatment for clients with allowable concurrent medical conditions.

Non-Covered Services for Adults

The following services are not covered for adults:

- Preventive services: prophylaxis, fluoride treatment and oral hygiene instruction
- Treatment for dental caries, gingivitis and tooth fractures
- Restorative and cosmetic procedures
- Inlay or onlay restorations
- Crowns, bridges, and implants
- Full and partial dentures: including assessment or preparation of the oral cavity for delivery of dentures/partials and bridges or subsequent adjustments to dentures/partials and bridges including treatment of pain or soreness from the wearing of dentures or any other fixed or removable prosthetic appliance.
- Alveoloplasty, vestibuloplasty, and excision of bone tissue
- Full mouth extractions

Emergency Treatment for Oral Cavity Conditions

Adult clients who present with an acute oral cavity condition that requires hospitalization and/or immediate surgical care are eligible for emergency treatment. Only the most limited services needed to correct the emergency condition are allowed. Emergency treatment of oral cavity conditions does not require a PAR.

Emergency treatment provided to an adult client includes:

- Immediate treatment or surgery to repair trauma to the jaw
- Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose
- Extraction of tooth or tooth structures associated with the emergency treatment of a condition of the oral cavity
- Repair of traumatic oral cavity wounds

Anesthesia services ancillary to the provision of emergency treatment

Code Table for Adult Emergency Treatment of Oral Cavity Conditions

Clinical Oral Evaluations	
D0140	limited oral evaluation - problem focused

Radiographs/Diagnostic Imaging (Including Interpretation)	
D0220	intraoral - periapical - first film
D0230	intraoral - each additional film
D0240	intraoral - occlusal film
→ limit is 2 per date of service	
D0250	extraoral - single film
D0260	extraoral - each additional film
D0270	bitewing - single film
D0272	bitewings - two films

Radiographs/Diagnostic Imaging (Including Interpretation)	
D0274	bitewings – four films
D0277	vertical bitewings 7 to 8 films
D0330	panoramic film

Tests and Examinations	
D0415	collection of microorganisms for culture and sensitivity
D0460	pulp vitality tests

Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap
D7220	removal of impacted tooth - soft tissue
D7230	removal of impacted tooth - partially bony
D7240	removal of impacted tooth - completely bony
D7250	surgical removal of residual tooth roots (cutting procedure)

Other Surgical Procedures	
D7285	biopsy of oral tissue - hard (bone, tooth)
D7286	biopsy of oral tissue – soft

Surgical Excision of Soft Tissue Lesions	
D7410	excision of benign lesion up to 1.25cm
D7411	ASSIST excision of benign lesion greater than 1.25cm
D7412	ASSIST excision of benign lesion, complicated
D7413	ASSIST excision of malignant lesion up to 1.25 cm
D7414	ASSIST excision of malignant lesion greater than 1.25 cm
D7415	ASSIST excision of malignant lesion, complicated
D7440	excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	ASSIST excision of malignant tumor – lesion diameter greater than 1.25cm
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25cm
D7451	ASSIST removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25cm
D7461	ASSIST removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7465	destruction of lesion(s) by physical or chemical method, by report.

Surgical Incision	
D7510	incision & drainage of abscess - intraoral soft tissue
D7520	incision & drainage of abscess - extraoral soft tissue
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	removal of reaction-producing foreign bodies, musculoskeletal system,
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of Fractures - Simple	
D7610	maxilla - open reduction (teeth immobilized, if present)
D7620	maxilla - closed reduction (teeth immobilized, if present)

Treatment of Fractures - Simple	
D7630	mandible - open reduction (teeth immobilized, if present)
D7640	mandible - closed reduction (teeth immobilized, if present)
D7650	malar &/or zygomatic arch - open reduction
D7660	malar &/or zygomatic arch - closed reduction
D7670	alveolus – closed reduction, may include stabilization of teeth
D7671	alveolus – open reduction, may include stabilization of teeth
D7680	facial bones - complicated reduction with fixation & multiple surgical approaches

Treatment of Fractures - Compound	
D7710	ASSIST maxilla - open reduction
D7720	ASSIST maxilla - closed reduction
D7730	ASSIST mandible - open reduction
D7740	ASSIST mandible - closed reduction
D7750	ASSIST malar &/or zygomatic arch - open reduction
D7760	ASSIST malar &/or zygomatic arch - closed reduction
D7770	ASSIST alveolus - open reduction stabilization of teeth
D7771	alveolus – closed reduction stabilization of teeth
D7780	ASSIST facial bones - complicated reduction with fixation & multiple surgical approaches

Reduction of Dislocation & Management of Other Temporomandibular Joint Dysfunction	
D7810	open reduction of dislocation
D7820	closed reduction of dislocation
D7830	manipulation under anesthesia

Repair of Traumatic Wounds	
D7910	suture of recent small wounds up to 5 cm

Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)	
D7911	complicated suture - up to 5 cm
D7912	complicated suture - greater than 5 cm

Other Repair Procedures	
D7990	emergency tracheotomy
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	ASSIST unspecified oral surgery procedure by report

Unclassified Treatment	
D9110	palliative (emergency) treatment of dental pain – minor procedure

Anesthesia	
D9220	deep sedation/general anesthesia – first 30 minutes
D9221	deep sedation/general anesthesia – each additional 15 minutes
D9241	intravenous conscious sedation/analgesia – first 30 minutes
D9242	intravenous conscious sedation/analgesia – each additional 15 minutes

Professional Consultation	
D9310	consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)

Professional Consultation
→ Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes. May be billed fee-for service by enrolled dentist providing services in outpatient hospital setting or ambulatory surgical center.

Professional Visits	
D9420	hospital or surgical center call

Non-Emergency Treatment for Adults with Concurrent Medical Condition

Adult clients with one or more concurrent medical conditions are eligible to receive non-emergency treatment of the oral cavity. **Only the concurrent medical conditions listed below, or chronic medical conditions that are exacerbated by a condition of the oral cavity as documented by the dentist, qualify an adult client for services.** A PAR is required for these services; the table below describes what must be included in the PAR. Do not submit x-rays with any PAR.

Allowable Conditions

Allowable Concurrent Medical Conditions	Required Information to be Included with all Prior Authorization Requests
• Neoplastic disease requiring chemotherapy and/or radiation • Pre and post organ transplant • Pregnancy • Chronic medical condition in which there is documentation that the medical condition is exacerbated by the condition of the oral cavity	• Dentist's statement describing the approved concurrent medical condition and the oral cavity condition. • The client's physician should submit adequate, clear, and concise evidence of how the concurrent medical condition is exacerbated by the oral cavity condition and why it is necessary to provide treatment. This information should be submitted with the dentist's PAR.

Code Table for Non-Emergency Treatment for Adults with a Concurrent Medical Condition

Clinical Oral Evaluations	
D0140	limited oral evaluation - problem focused
D0150	PAR comprehensive oral evaluation – new or established patient
D0160	PAR detailed & extensive oral evaluation - problem focused, by report
D0180	PAR comprehensive periodontal evaluation-new or established patient
→ limited to independent hygienists only	

Radiographs/Diagnostic Imaging (Including Interpretation)	
▲D0210	PAR intraoral - complete series (including bite wings)
▲D0220	intraoral - periapical - first film
▲D0230	intraoral - each additional film
▲D0240	intraoral - occlusal film
▲D0250	extraoral - single film
▲D0260	extraoral - each additional film
▲D0270	bitewing - single film

Radiographs/Diagnostic Imaging (Including Interpretation)	
▲D0272	bitewings - two films
▲D0274	bitewings - four films
▲D0290	PAR posterior-anterior or lateral skull & facial bone survey film
D0310	PAR sialography
D0320	PAR temporomandibular joint arthrogram, including injection
▲D0321	PAR other temporomandibular joint films, by report
D0322	PAR tomographic survey
▲D0330	panoramic film

Tests and Examinations	
D0415	collection of microorganisms for culture and sensitivity
D0460	pulp vitality tests
→ includes multiple teeth & contralateral comparison/s	
D0470	PAR diagnostic casts
→ includes both maxillary and mandibular casts	

Periodontics	
D4210	PAR gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	PAR gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant
D4240	PAR gingival flap procedure, including root planning, four or more contiguous teeth or tooth bounded spaces, per quadrant

Non-Surgical Periodontal Service	
▲D4321	PAR provisional splinting – extracoronal
D4341	PAR periodontal scaling and root planing - four or more teeth per quadrant
D4355	PAR full mouth debridement to enable comprehensive evaluation and diagnosis
D4381	PAR localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report
D5982	PAR surgical stent
D5983	PAR radiation carrier
D5984	PAR radiation shield
D5985	PAR radiation cone locator
D5987	PAR commissure splint
D5988	PAR surgical splint
●D5992	adjust maxillofacial prosthetic appliance, by report

Extraction	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)	
▲D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap
D7220	removal of impacted tooth - soft tissue
D7230	removal of impacted tooth - partially bony
D7240	removal of impacted tooth - completely bony
D7250	surgical removal of residual tooth roots (cutting procedure)

Other Surgical Procedures	
D7260	oroantral fistula closure
D7261	primary closure of sinus perforation
D7285	biopsy of oral tissue - hard (bone, tooth)
D7286	biopsy of oral tissue – soft
▲D7295	PAR ASSIST harvest of bone for use in autogenous grafting procedure

Surgical Excision of Reactive Inflammatory Lesions	
D7410	excision of benign lesion up to 1.25 cm
D7411	ASSIST excision of benign lesion greater than 1.25 cm
D7412	ASSIST excision of benign lesion, complicated
D7413	ASSIST excision of malignant lesion up to 1.25 cm
D7414	ASSIST excision of malignant lesion greater than 1.25 cm
D7415	ASSIST excision of malignant lesion, complicated

Removal of Tumors, Cysts & Neoplasm	
D7440	excision of malignant tumor - lesion diameter up to 1.25cm
D7441	ASSIST excision of malignant tumor - lesion diameter greater than 1.25cm
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25cm
D7451	ASSIST removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25cm
D7461	ASSIST removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7465	destruction of lesion(s) by physical or chemical method, by report

Excision of Bone Tissue	
D7485	PAR surgical reduction of osseous tuberosity
D7490	PAR radical resection of maxilla or mandible

Surgical Incision	
D7510	incision & drainage of abscess - intraoral soft tissue
D7520	incision & drainage of abscess - extraoral soft tissue
D7530	removal of foreign body from mucosa, skin or subcutaneous alveolar tissue
D7540	removal of reaction-producing foreign bodies – musculoskeletal system
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of Fractures - Simple	
D7610	maxilla - open reduction (teeth immobilized, if present)
D7620	maxilla - closed reduction (teeth immobilized, if present)
D7630	mandible - open reduction (teeth immobilized, if present)
D7640	mandible - closed reduction (teeth immobilized, if present)
D7650	malar &/or zygomatic arch - open reduction
D7660	malar &/or zygomatic arch - closed reduction
D7670	alveolus – closed reduction, may include stabilization of teeth
D7671	alveolus – open reduction, may include stabilization of teeth
D7680	facial bones - complicated reduction with fixation & multiple surgical approaches

Treatment of Fractures - Compound	
D7710	ASSIST maxilla - open reduction
D7720	ASSIST maxilla - closed reduction
D7730	ASSIST mandible - open reduction
D7740	ASSIST mandible - closed reduction
D7750	ASSIST malar &/or zygomatic arch - open reduction
D7760	ASSIST malar &/or zygomatic arch - closed reduction
D7770	ASSIST alveolus – open reduction stabilization of teeth
D7771	alveolus – closed reduction stabilization of teeth
D7780	ASSIST facial bones - complicated reduction with fixation & multiple surgical approaches

Reduction of Dislocation & Management of Other Temporomandibular Joint Dysfunction	
D7810	open reduction of dislocation
D7820	closed reduction of dislocation
D7830	manipulation under anesthesia
D7840	PAR ASSIST condylectomy
D7850	PAR ASSIST surgical discectomy, with/without implant
D7852	PAR ASSIST disc repair
D7854	PAR ASSIST synovectomy
D7856	PAR ASSIST myotomy
D7858	PAR ASSIST joint reconstruction
D7860	PAR ASSIST arthrotomy
D7865	PAR ASSIST arthroplasty
D7870	PAR ASSIST arthrocentesis
D7871	PAR ASSIST non-arthroscopic lysis and lavage
D7872	PAR ASSIST arthroscopy – diagnostic, with or without biopsy
D7873	PAR ASSIST arthroscopy - surgical: lavage & lysis of adhesions
D7874	PAR ASSIST arthroscopy - surgical: disc repositioning & stabilization
D7875	PAR ASSIST arthroscopy - surgical: synovectomy
D7876	PAR ASSIST arthroscopy - surgical: discectomy
D7877	PAR ASSIST arthroscopy - surgical: debridement
D7880	PAR occlusal orthotic device, by report
D7899	PAR ASSIST unspecified TMD therapy, by report

Repair of Traumatic Wounds	
D7910	suture of recent small wounds up to 5cm

Complicated Suturing	
(Reconstruction requiring delicate handling of tissues & wide undermining for meticulous closure)	
D7911	complicated suture - up to 5cm
D7912	complicated suture - greater than 5cm

Other Repair Procedures	
D7920	PAR ASSIST skin graft (identify defect covered, location and type of graft)
D7950	PAR ASSIST osseous, osteoperiosteal or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7955	PAR ASSIST repair of maxillofacial soft and/or hard tissue defect
D7980	PAR sialolithotomy

Other Repair Procedures	
D7981	PAR ASSIST excision of salivary gland, by report
D7982	PAR sialodochoplasty
D7983	PAR closure of salivary fistula
D7990	emergency tracheotomy
D7991	PAR ASSIST coronoidectomy
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	PAR ASSIST unspecified oral surgery procedure, by report

Unclassified Treatment	
D9110	palliative (emergency) treatment of dental pain – minor procedure

Anesthesia	
D9220	deep sedation/general anesthesia – first 30 minutes
D9221	deep sedation/general anesthesia – each additional 15 minutes
D9241	intravenous conscious sedation/analgesia – first 30 minutes
D9242	intravenous conscious sedation/analgesia – each additional 15 minutes

Professional Consultation	
D9310	PAR consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)

Professional Visits	
▲D9420	hospital or ambulatory surgical center call
→ Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes. May be billed fee-for service by enrolled dentist providing services in outpatient hospital setting or ambulatory surgical center.	

Benefits for Non-Citizens

Non-citizen clients are eligible for emergency treatment if the client presents with an acute oral cavity condition that requires hospitalization and/or immediate surgical care. **Only the most limited service(s) needed to correct the emergency oral cavity condition(s) are allowed.**

Emergency treatment provided to a non-citizen client includes:

- Immediate treatment or surgery to repair trauma to the jaw
- Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose.
- Extraction of tooth or tooth structures associated with the emergency treatment of a condition of the oral cavity
- Repair of traumatic oral cavity wounds
- Anesthesia services ancillary to the provision of emergency treatment

Please refer to the coding reference guide below for the only codes available for billing treatment of emergency oral cavity conditions for non-citizen clients.

Code Table for Non-Citizen Benefits

Clinical Oral Evaluations	
D0140	limited oral evaluation - problem focused

Clinical Oral Evaluations	
Radiographs/Diagnostic Imaging (Including Interpretation)	
D0220	intraoral - periapical - first film
D0230	intraoral - each additional film
D0240	intraoral - occlusal film
D0250	extraoral - single film
D0260	extraoral - each additional film
D0270	bitewing - single film
D0272	bitewings - two films
D0330	panoramic film

Tests and Examinations	
D0415	collection of microorganisms for culture and sensitivity

Extraction	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)	
▲D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap
D7220	removal of impacted tooth - soft tissue
D7230	removal of impacted tooth - partially bony
D7240	removal of impacted tooth - completely bony
D7250	surgical removal of residual tooth roots (cutting procedure)

Other Surgical Procedures	
D7285	biopsy of oral tissue - hard (bone, tooth)
D7286	biopsy of oral tissue – soft
Surgical Excision of Soft Tissues Lesions	
D7411	ASSIST excision of benign lesion greater than 1.25cm
D7412	ASSIST excision of benign lesion, complicated
D7413	ASSIST excision of malignant lesion up to 1.25 cm
D7414	ASSIST excision of malignant lesion greater than 1.25 cm
D7415	ASSIST excision of malignant lesion, complicated

Surgical Excision of Intra-Osseous Lesions	
D7440	excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	ASSIST excision of malignant tumor – lesion diameter greater than 1.25cm
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25cm
D7451	ASSIST removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25cm
D7461	ASSIST removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25cm
D7465	destruction of lesion(s) by physical or chemical method, by report.

Surgical Incision	
D7510	incision & drainage of abscess - intraoral soft tissue
D7520	incision & drainage of abscess - extraoral soft tissue
D7530	removal of foreign body from mucosa, skin or subcutaneous alveolar tissue
D7540	removal of reaction-producing foreign bodies, musculoskeletal system

Surgical Incision	
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of Fractures - Simple	
D7610	maxilla - open reduction (teeth immobilized, if present)
D7620	maxilla - closed reduction (teeth immobilized, if present)
D7630	mandible - open reduction (teeth immobilized, if present)
D7640	mandible - closed reduction (teeth immobilized, if present)
D7650	malar &/or zygomatic arch - open reduction
D7660	malar &/or zygomatic arch - closed reduction
D7670	alveolus – closed reduction, may include stabilization of teeth
D7671	alveolus – open reduction, may include stabilization of teeth
D7680	facial bones - complicated reduction with fixation & multiple surgical approaches

Treatment of Fractures - Compound	
D7710	ASSIST maxilla - open reduction
D7720	ASSIST maxilla - closed reduction
D7730	ASSIST mandible - open reduction
D7740	ASSIST mandible - closed reduction
D7750	ASSIST malar &/or zygomatic arch - open reduction
D7760	ASSIST malar &/or zygomatic arch - closed reduction
D7770	ASSIST alveolus - open reduction stabilization of teeth
D7771	alveolus – closed reduction stabilization of teeth
D7780	ASSIST facial bones - complicated reduction with fixation & multiple surgical approaches

Reduction of Dislocation & Management of Other Temporomandibular Joint Dysfunction	
D7810	open reduction of dislocation
D7820	closed reduction of dislocation
D7830	manipulation under anesthesia

Repair of Traumatic Wounds	
D7910	suture of recent small wounds up to 5 cm

Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)	
D7911	complicated suture - up to 5 cm
D7912	complicated suture - greater than 5 cm

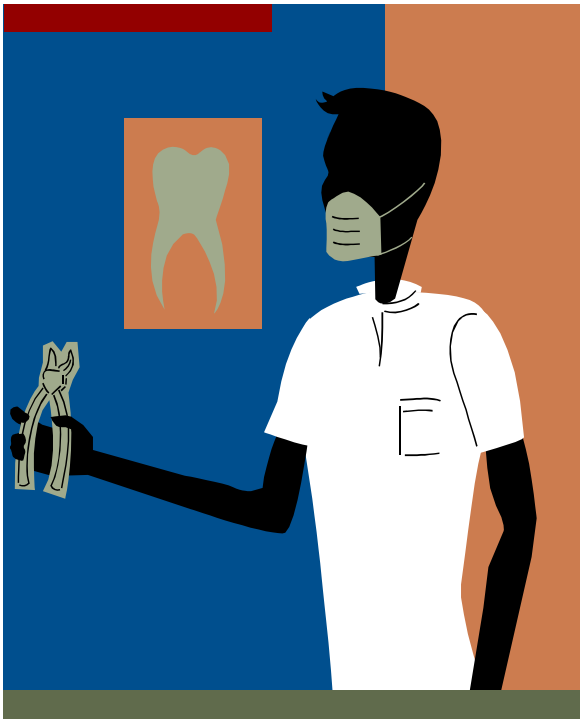
Other Repair Procedures	
D7990	emergency tracheotomy

Unclassified Treatment	
D9110	palliative (emergency) treatment of dental pain – minor procedure

Anesthesia	
D9220	deep sedation/general anesthesia – first 30 minutes
D9221	deep sedation/general anesthesia – each additional 15 minutes
D9241	intravenous conscious sedation/analgesia – first 30 minutes
D9242	intravenous conscious sedation/analgesia – each additional 15 minutes

Anesthesia
→ Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes. May be billed fee-for service by enrolled dentist providing services in outpatient hospital setting or ambulatory surgical center.

Professional Visits	
▲D9420	hospital or ambulatory surgical call



2006 ADA PAR Example

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ■ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number: C223344

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
ColoradoPAR Program
55 N. Robinson Avenue, Suite 600
Oklahoma City, OK 73102
1-888-454-7686

OTHER COVERAGE

4. Other Dental or Medical Coverage? ■ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Client, Ima D.
123 Main St.
Anytown, CO 88888

13. Date of Birth (MM/DD/CCYY): 01/01/2006 | 14. Gender ☐ M ■ F | 15. Policyholder/Subscriber ID (SSN or ID#): A123456

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ■ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1			JP	3		D2751	Crown - porcelain fused to predominately base metal	500 00
2			JP	19		D2751	Crown - porcelain fused to predominately base metal	500 00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
X	2	3	4	5	6	X	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee: 1000 00

35. Remarks
Tooth #3 has RCT and needs a crown. Tooth #19 has large MODBL build-up with recurrent decay and needs the protection of crown coverage.

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ■ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ■ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
The Dental Group
321 Any St.
Anytown, CO 88888

49. NPI: 1010101010 | 50. License Number | 51. SSN or TIN

52. Phone Number: (333) 456 - 7690 | 52A. Additional Provider ID: 12345678

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X *I. M. Provider, DDS* 01/15/2014
Signed (Treating Dentist) Date

54. NPI: 1234567890 | 55. License Number: 9999

56. Address, City, State, Zip Code: 321 Any St., Anytown, CO 88888 | 56A. Provider Specialty Code

57. Phone Number: (333) 456 - 7690 | 58. Additional Provider ID: 87654321

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

2006 ADA Claim Example

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
- [■] Statement of Actual Services
- [ ] Request for Predetermination / Preauthorization
- [■] EPSDT / Title XIX

2. Predetermination / Preauthorization Number: C223344

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code:
Colorado Medical Assistance Program
Claims and PARs
P.O. Box 30
Denver, CO 80201-0030

OTHER COVERAGE

4. Other Dental or Medical Coverage? [■] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:
Client, Ima D.
123 Main St.
Anytown, CO 88888

13. Date of Birth (MM/DD/CCYY): 01/01/2006 | 14. Gender [ ] M [■] F | 15. Policyholder/Subscriber ID (SSN or ID#): A123456

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [■] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Student Status [ ] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender [ ] M [ ] F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	01/15/2014					D5510	Repair broken complete denture base	100 00
2	01/15/2014			28	MOD	D2160	Amalgam	50 00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee: 150 00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: [■] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? [■] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from: [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code:
The Dental Group
321 Any St.
Anytown, CO 88888

49. NPI: 1010101010 | 50. License Number | 51. SSN or TIN

52. Phone Number: (333) 456 - 7690 | 52A. Additional Provider ID: 12345678

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53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X *I. M. Provider, DDS* 01/15/2014
Signed (Treating Dentist) Date

54. NPI: 1234567890 | 55. License Number: 9999

56. Address, City, State, Zip Code: 321 Any St., Anytown, CO 88888 | 56A. Provider Specialty Code

57. Phone Number: (333) 456 - 7690 | 58. Additional Provider ID: 87654321

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in Provider Services Billing Manuals section of the Department's Web sitehttp://www.colorado.gov/hcpf.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➤ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➤ *Colorado 1500*: Indicate "LBOD" and the date in box 30 - Remarks. ➤ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks.
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied: **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Client Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Client Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name • States that eligibility was backdated or retroactive Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare Standard Paper Remit (SPR) date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR. Maintain the original SPR on file. **LBOD** = the Medicare processing date shown on the SPR .
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the SPR. Maintain the original SPR on file. **LBOD** = the Medicare processing date shown on the SPR .
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.

Billing Instruction Detail	Instructions
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific client, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Client Changes Providers during Obstetrical Care	The claim is for obstetrical care (OB) where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

Colorado Medical Assistance Program

Dental Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ **Date:** _____

This document is an addendum to ADA Dental Claim forms and this document is required per 42 C.F.R. 455.18 (a)(1-2) to be attached to dental claims that are submitted for payment by paper.

ADA Dental Billing Manual Revisions Log

Revision Date	Section/Action	Pages	Made by
02/13/2008	*Electronic claims – updated first two paragraphs with bullets*	*12*	*pr-z*
04/07/2008	*Corrected link to Dental Certification link*	*2*	*jg*
04/07/2007	*Changed link to Assistant Surgeon form*	*9*	*jg*
11/05/2008	*Updated web addresses*	*Throughout*	*jg*
01/07/2009	*Updated information*	*Throughout*	*jg*
03/08/2010	*Updated Web site links*	*Throughout*	*jg*
04/21/2010	*Added link to Program Rules*	*3*	*jg*
04/21/2010	*Updated Billing information*	*4-6*	*jg*
04/21/2010	*Updated Orthodonic bulletin link to 2010 bulletin, B1000279*	*3, 8 & 10*	*jg*
04/21/2010	*Updated Dental bulletin links*	*3, 9 & 15*	*jg*
04/21/2010	*Changed website to Web site*	*3, 10, 12 & 28*	*jg*
04/21/2010	*Changed date for "Handicapping Malocclusion Assessment" form from 2009 to 2010*	*8*	*jg*
04/21/2010	*Added link to Specifications*	*10*	*jg*
12/05/2011	*Replaced 997 with 999* *Replaced http://www.wpc-edi.com/hipaa with http://www.wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*6* *5* *5*	*ss*
04/03/2012	*Added bulletin links* *Updated assistant surgeon PAR wording* *Updated example in Field 13* *Updated LBOD instructions*	*3, 16 & 17* *18* *23* *32 & 33*	*jg*
05/13/2013	*Revised Electronic Claims* *Added HCPCS to manual* *Added:* • *D0190, D0191, D0364, D0365, D0366, D0367, D0381, D0382, D4212, D4277, D4278* *Deleted:* • *D1203, D1204, D4271, D6254, D6795, D6970, D6970, D6972, D6973, D6976, D6977*	*3* *29-54*	*cc*
11/06/2013	*Updated ColoradoPAR address*	*3*	*jg*
01/24/2014	*Deleted codes: D3354, D5860 & D5861* *Reformatted* *Updated PAR and claim examples*	*29 & 32* *Throughout* *49 & 50*	*jg*

Revision Date	Section/Action	Pages	Made by
01/25/2014	*Updated TOC*	*i & ii*	*jg*
04/14/2014	*Updated per the new Adult Dental benefit effective 4/1/14*	*Throughout*	*dm/cc*
04/14/2014	*Formatted* *Updated TOC*	*Throughout* *i & ii*	*jg*
05/14/2014	*Updated billing manual for removal of the Primary Care Physician Program*	*15*	*mm*

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.*